

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County Balto.
 City or town Waters of Carroll's In Pa.
 How long in above place of death? 1 day
 Hospital, institution, or other address where death occurred Chesapeake Bay
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For foreign infants give residence of mother)

State Pa. County Adams
 City or town Lincoln Hgts
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. World War II II
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II II

3. (a) FULL NAME

Raymond C. Allen.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Wife

7. Birth date of deceased (mo., day, yr.) May 30 - 1922
 8. AGE: Years 26 Months 0 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace Waco, Pa.
 (Town, county, and state)

10. Usual occupation Labourer11. Industry or business Saw mill12. Name William H. Allen13. Birthplace Waco, Pa.14. Maiden name Fannie Bassett15. Birthplace Waco, Pa.16. Informant Wm. H. AllenAddress Route 14, Box 717, Balto. 20

17. (Burial, cremation, or removal, Which?) Burial Date thereof Sept 4 - 48
 (month) (day) (year)

Cemetery or crematory Washington ParkLocation Chesapeake Bay18. Funeral director John S. ConnollyAddress 415 Eastern Ave19. (Date rec'd by registrar) Sept 18 Registrar John S. Connolly

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 48 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Drowning accidental 9/1/48

Due to.....

Body recovered 9/4/48

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

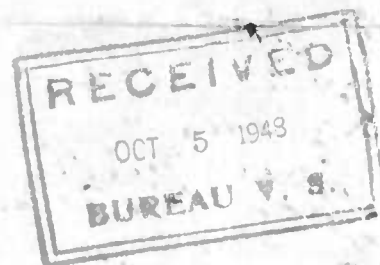
Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/1/48Where did injury occur Waters of Carroll's In Pa. (City or town) (State)Injured at home, farm, industry, public place (where?) BeachMeans of injury Drowning Injured at work no23. SIGNATURE Dr. J. M. Baranovic M.D.Address Balto. Co. Dumbalk Date signed 9/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 09125
 Reg. Diat. No. **36**

1. PLACE OF DEATH:

 County Balto
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Convalescent Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md. County Balto
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. Edmondson Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John A. Armour

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed
6. (b) Name of husband or wife Maria L. Armour7. Birth date of deceased (mo., day, yr.) Dec 5th 1853

8. AGE: Years Months Days If less than one day

94 9 16 hrs. min.
9. Birthplace Manchester N. H.
(Town, county, and state)10. Usual occupation Marble Cutter11. Industry or business Own Business12. Name William Armour13. Birthplace Scotland14. Maiden name Isabelle Denny15. Birthplace Scotland16. Informant Mrs Isabelle A. SchoradenAddress 209 Glenmore Ave17. Burial Date thereof 9/24/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory LorraineLocation Balto Co. Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 9/23/48 Alv. Hedlund

(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1948 at 3 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to Sept 21 1948and that I last saw him alive on Sept 21 1948Immediate cause of death Cerebral Hemorrhage

DURATION

Due to Generalized ArterioSclerosisDue to Ischemic

Differ conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alv. Hedlund

M. D. or other

Address Catonsville Date signed 9-22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09126-35

1. PLACE OF DEATH:

County BaltimoreCity or town PARKTON
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORECity or town PARKTON
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war. _____

3. (a) FULL NAME

ANNA MARY BACON

3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife ROBERT S. BACON7. Birth date of deceased (mo., day, yr.) August 19, 1964

6. (c) If alive, give age _____ years

8. AGE: Years 84 Months 0 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace BALTIMORE Co
(Town, county, and state)10. Usual occupation AT HOME

11. Industry or business

12. Name HARRISON ALMOND13. Birthplace BALTIMORE Co14. Maiden name ELIZABETH HYRES15. Birthplace HARFORD Co16. Informant Mrs. Louis P. MarshallAddress Parkton, Md.17. Burial Date thereof Sept 4-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory VERNONLocation WHITE HALL - RFD18. Funeral director Harold S. MarklineAddress White Hall, Md.19. Sept. 1, 1948 Mrs. Howard S. Markline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1948, at 4 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

85 to Sept. 1 1948and that I last saw her alive on Sept. 1 1948Immediate cause of death Chronic myocarditis

DURATION

Due to _____

Due to _____

Other conditions HypertensionAnterior - chronic

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

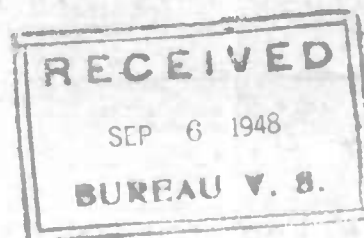
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. FranceParkton, Md. M. D. or other _____Address _____ Date signed 9/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 177 days
 Hospital, institution, or street addresses where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
 How long in hospital or institution? 177 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1308 N. Mount St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-1

3. (a) FULL NAME

EDWARD BROWN

3. (b) Social Security Number

217-07-1662

4. Sex Male 5. Color or race col. 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Anne Brown
 8. (c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) January 31, 1897
 8. AGE: Year 51 Month 7 Day 10 If less than one day _____ hrs. _____ min.

9. Birthplace Prince George Co., Va.
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Benjamin Brown
 13. Birthplace Virginia
 14. Maiden name Nellie Leslie
 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Md.

17. Burial Date thereof Sept. 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery
 Location Baltimore City

18. Funeral director George G. Nelson
 Address 1303 Pressman Street

19. Sept. 14, 1948 C. W. Hedges
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 19 48 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 19 48 to Sept. 11 19 48

and that I last saw him alive on September 11 19 48

Immediate cause of death TUBERCULOSIS, PULMONARY
CHRONIC FIBROID, FAR ADVANCED,
ACTIVE

DURATION

Approx.
1 year

Due to _____

Due to _____

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. P. DOENGES, M. D. M. D. or other _____

Address VAR. Ft. Howard, Md. Date signed 9-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09128

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Eosy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Eosy
(If outside city or town limits, write RURAL and give nearest town)Street No. 522 Elmore Ave.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary Lizzie Campbell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

John Campbell

7. Birth date of

deceased (mo., day, yr.)

July 28 - 1878

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

7070

hrs.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

George Bettman

13. Birthplace

Germany

MOTHER

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

Mrs. Christina R. Albert

Address

522 Elmore Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 1 - 1948

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Rd.

18. Funeral director

Address

John G. Connelley
418 Eastern Ave. Eosy

19.

(Date rec'd by registrar)

Sept. 291948John G. Connelley

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1948, at 4:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 28 1948, to Sept. 28 1948and that I last saw him alive on Sept. 27 1948

Immediate cause of death

Cerebral thrombosishemiplegiamyocarditis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell Edmund408 Eastern Ave. Eosy M. D. or otherAddress 408 Eastern Ave. Eosy Date signed 9-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

812 Regester Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 102 W. Oakdale Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EMMA BLANCHE CANNADAY

3. (b) Social Security Number

no

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

femalewhitewidow6. (b) Name of husband or wife Richard F. Cannaday7. Birth date of deceased (mo., day, yr.) Sept. 4, 1865

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
82 11 27 hrs. min.9. Birthplace Floyd Co., Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Robert Huff13. Birthplace Va.14. Maiden name Mary Kefauver15. Birthplace Va.16. Informant Dr. R. G. CannadayAddress 121 E. 60th St., New York City, N.Y.17. Burial Date thereof 9/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid Ridge Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Baltimore, Md.19. Sept 3 1948 A. M. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 19 48, at 1:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/14 19 43, to 9/1 19 48and that I last saw her alive on 8/31 19 48Immediate cause of death SenilityDue to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Chesdorny M. D. or otherAddress 2923 St Paul Rd Date signed 9/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

527 Compass Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. 527 Compass Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grover H. Carrico

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ida (Leffman)

7. Birth date of deceased (mo., day, yr.)

Jan - 20 18856. (c) If alive, give age 65 years

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

North Carolina
(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Glenn S. Martin Co.

12. Name

Albert Carrico

13. Birthplace

Virginia

14. Maiden name

Caroline Higgins

15. Birthplace

Virginia

16. Informant

Mrs. Ida Carrico

Address

527 Compass Rd

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Sept. 7 - 48

Cemetery or crematory

Oak Grove

Location

Belair, Md.

18. Funeral director

John S. Connolly

Address

418 Eastern Ave

19.

(Date rec'd by registrar)

Sept 6 - 48

19.

John S. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/48 19 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Strangulation

Due to

Strangulation

Due to

Strangulation

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

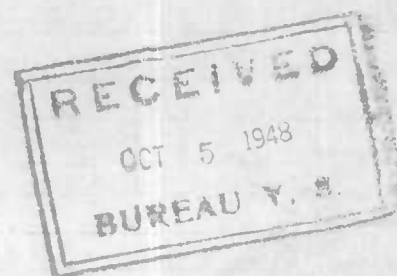
Accident, suicide, or homicide homicide Date of 9/5/48Where did injury occur? Bedroom, 418 Eastern Ave, Belair, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Strangulation from door Injured at work? No

23. SIGNATURE

John S. Connolly M.D. or otherAddress 418 Eastern Ave, Belair, Md. Date signed 9/5/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

09131

93d

1. PLACE OF DEATH

County... 13g. CluniasCity or town... Randallstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ... 15 years

Hospital, institution, or street address where death occurred...

How long in hospital or institution? ... —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No. ... Liberty Road
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Harmon A. Claggett

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widower8.(b) Name of husband or wife... Emma Claggettdeceased

7. Birth date of

deceased (mo., day, yr.)

Nov - 4 - 1871

8. AGE: Years Months Days

76 10 14 hrs. min.9. Birthplace... Baltimore County md

(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

12. Name... Adam Claggett13. Birthplace... Balto. Co. MarylandKelhor

14. Maiden name...

15. Birthplace... Balto. Co. md16. Informant... Carrie Emma FrankAddress... Randallstown md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... Sept 20, 1948

(month) (day) (year)

Cemetery or crematory... Holy FamilyLocation... Harrisonville, Maryland18. Funeral director... Frank H. NewellAddress... Pikeville, Maryland19. 9/19/48 19 48

(Date rec'd by registrar)

Registrar

20. DATE OF DEATH... Sept 18 19 48 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1st 19 48 to Sept 18 19 48and that I last saw him alive on Sept 17 19 48

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 18 19 48 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1st 19 48 to Sept 18 19 48and that I last saw him alive on Sept 17 19 48

Immediate cause of death...

Cardio Vascular Disease

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... Tom E. MartinAddress... RandallstownDate signed... 9/19/48

M. D. or other

CERTIFICATE OF DEATH

RECEIVED
OCT 7 1943
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09132

44

1. PLACE OF DEATH:

County Balto.

City or town Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Bert River Beach Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD County Balto.

City or town Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bert River Beach
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Virginia Mae Clarke.

3. (b) Social Security Number

4. Sex

Female

5. Color of race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Wm. C. Clarke.

7. Birth date of deceased (mo., day, yr.)

Nov 8/1912

6.(c) If alive, give age 39 years

8. AGE:

Years 35

Months 10

Days 19

If less than one day

hrs.

min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Joseph Hoyle

13. Birthplace

Cumberland Md.

14. Maiden name

Marie M. Williams

15. Birthplace

Matthews Co. Va.

16. Informant

Wm. C. Clarke (husband)

Address

above

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof Sept. 30 - 48
(month) (day) (year)

Cemetery or crematory

Cheney

Location

Chase Md.

18. Funeral director

John S. Connolly

Address

418 Eastern Ave. East

19.

Sept. 29 - 48
(Date rec'd by registrar)

John S. Connolly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 27, 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to, 19

and that I last saw him alive on 19

Immediate cause of death

Fracture base skull

Fracture cervical vertebrae

Fracture of lower tibia

Crushed left chest rib

Contusions & bruise burns

over thighs leg for scars

Left foot crushed

Birth flesh torn off

Date of op. Sept 27, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide Accident Date of 9/27/48

Where did injury occur? Chase Balto. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Automobile Injured at work? No

23. SIGNATURE

Deputy Medical Examiner
Balto Co. Dundalk Md. 9/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 1 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09133

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months

Hospital, institution, or street address where death occurred:

Rev. Opitz Nursing HomeHow long in hospital or institution? (MAMIE)

3. (a) FULL NAME

Mary Sarah Clayton

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife xx Harry Clayton7. Birth date of deceased (mo., day, yr.) August 8, 1859

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>1</u>	<u>18</u> hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Frederick C. Lindenberg13. Birthplace Germany14. Maiden name Not Known15. Birthplace Not Known16. Informant Mrs. Esther L. DowellAddress 508 E. 39th St.,17. Burial Date thereof 9-28-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory xx Mt. OlivetLocation Baltimore, Md.18. Funeral director G. Howard StrongAddress 3207 W. North Ave.,19. Sept 27 19 48 G. W. Helms
(Date read by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 508 E. 39th St.,
(If rural, give LOCATION)2. (a) If veteran, name war ✓

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1948, at A. 3.00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Sept 1948, to 26 Sept 1948, and that I last saw him alive on 26 Sept 1948.Immediate cause of death Cardiac failure, acute DURATION 1 dayDue to hypertensive and arteriosclerotic cardiovascular disease with myocardial degeneration

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil W. Henning, Jr. M.D.Address 4580 Edmondson Ave Date signed 27 Sept 48

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 3134

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore
 (b) City or town Danvers
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days) 10 hrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State MD (b) County Baltimore
 (c) City or town Danvers
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. (If rural give location)
 (e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME

Larry Collins (TWIN #2)

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex

M

5. Color or race

6 (a) Single, married, widowed, or divorced.

S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-16-48

8. AGE:

Years

Months

Days

If less than one day

10 hr. min.

9. Birthplace

Danvers, Baltimore Co., MD
 (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Oscar Collins

13. Birthplace

Virginia

14. Maiden Name

Marie Hattie Roberts

15. Birthplace

Tenn

16 (a) Informant

Hattie Marie Collins

(b) Address

Danvers

17 (a)

Burial

(b) Date thereof

9/17/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Good Shepherd

Location

Howard Co

18 (a) Funeral director

Parent

(b) Address

Danvers

19 (a)

10/27/48

(b)

Dr. E. Martin

Registrar

MEDICAL CERTIFICATION

20. Date of death Sept 27, 1948, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26/1948, to 9/27/1948, and that I last saw him alive on 9/26/1948.

Immediate cause of death

Cyanosis at birth with poor respiration, Congenital heart dis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature

Dr. E. Martin

M. D. or other

Address Randalltown

Date signed 9/27/48

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1945
BUREAU A. S.

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **XX**

09135

1. PLACE OF DEATH:

County **Baltimore**City or town **Fort Howard**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **3 days**

Hospital, institution, or street address where death occurred:

Vets Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? **3 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** CountyCity or town **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)Street No. **605 Pierce St.**
(If rural, give LOCATION)2.(a) If veteran, name war **WW I**

3.(a) FULL NAME

EDWARD COOK

3.(b) Social Security Number

Unknown

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male**Colored****Single**6.(b) Name of husband or wife **Single**

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **7-27-92**8. AGE: Years Months Days It less than one day
56 1 5 hrs. min.9. Birthplace **Middlesex, Virginia**
(Town, county, and state)10. Usual occupation **Ice man**

11. Industry or business

12. Name **Asie Cook**13. Birthplace **Middlesex, Va.**14. Maiden name **Unknown**15. Birthplace **Unknown**16. Informant **Clinical Records, Vets. Adm. Hospital**
Address **Fort Howard, Maryland**17. Burial Date thereof **9/7/48**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Baltimore National Cemetery**Location **Baltimore, Maryland**18. Funeral director **Charles R. Law**Address **802 Madison Ave. Balto., Md.**19. (Date, rec'd by registrar) **9/5** **xx RW Hedrick** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 2** 19**48** at **11:15 PM**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 30** 19**48** to **September 2** 19**48** and that I last saw him alive on **September 2** 19**48**Immediate cause of death **Cirrhosis of liver** DURATION **Unknown**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Data of op.

Autopsy results **Substantiated above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **H.C. MANAUGH** **H.C. MANAUGH, M.D. CHF. PROP. SERVICES**Address **VAH, Fort Howard, Md.** Date signed **9-3-48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09136

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto.
 City or town Below Wrothport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
3715 Annapolis Rd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto
 City or town Below Wrothport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3715 Annapolis Rd
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

George M. Cord Sr

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Annie E. Cord
 7. Birth date of deceased (mo., day, yr.) April 4th 1861
 6. (c) If alive, give age _____ years
 8. AGE: Years 87 Months 5 Days 6 It less than one day _____ hrs. _____ min.

9. Birthplace U.C.
 (Town, county, and state)
 10. Usual occupation at Home
 11. Industry or business
 12. Name George Cord
 13. Birthplace Unknown
 14. Maiden name Sarah Cruzen
 15. Birthplace

16. Informant Katherine Deannstadt
 Address 3715 Annapolis Rd - Balto. Co
 17. Burial Burial Date thereof 9/9/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Western
 Location Balto. Md.
 18. Funeral director William Cook Inc.
 Address 1217 St. Paul St
9/8 AP Helm
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1948 19 48, at 6²⁰ P. M.
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 1, 1945 to Sept 6, 1948
 and that I last saw him alive on Sept 6, 1948
 Immediate cause of death Acute Cardiac Failure DURATION 1 day
Myocardial Failure
 Due to Cardiac decompensation [10/22/48 ahe]
 Other conditions

(Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?
 23. SIGNATURE Louis J. Glavin MD M. D. or other
 Address Abingdon Md Date signed _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09144

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, MarylandHow long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County.....City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2229 Division Street
(If rural, give LOCATION)2.(a) If veteran, name war WW II

3. (a) FULL NAME

ISAAC H. DAVIS

3. (b) Social Security Number

Unknown

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single6. (b) Name of husband or wife Single

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 5-29-068. AGE: Years Months Days If less than one day
42 3 11 hrs. min.9. Birthplace Morehead City, N. C.
(Town, county, and state)10. Usual occupation Press Operator

11. Industry or business

12. Name Amos Davis13. Birthplace North Carolina14. Maiden name Eula Henderson15. Birthplace North Carolina18. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. BURIAL Date thereof 9/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PrivateLocation Morehead City, N.C.18. Funeral director Charles LawAddress 802 Madison Ave. Balto. Md.19. Sept. 11 19 48 William M. Kelly Jr.
(Date rec'd by registrar) (Year) (Month) (Day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 19 48 4:10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 19 48 to Sept. 10 19 48and that I last saw him alive on September 10 19 48Immediate cause of death Pericardial Tamponade DURATION 2 daysDue to Metastatic tumor in pericardium

Due to

Other conditions Tumor of lung with metastases 3 mos.
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Russell Brandon, M. D.23. SIGNATURE RUSSELL BRANDON, M.D. M. D. or otherAddress VAH. Ft. Howard, Md. Date signed 9-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09138

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville -8, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville-8, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Church Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Florence Davis

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife John Joseph Davis7. Birth date of deceased (mo., day, yr.) Nov. 19, 1866

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>9</u>	<u>24</u>hrs.min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Home duties

11. Industry or business

12. Name Arthur Chenoweth13. Birthplace Md.14. Maiden name Harriet Jones15. Birthplace Md.16. Informant Harriet J. DavisAddress Pikesville, Md.17. Burial Date thereof Sept 15-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Pikesville, Md.18. Funeral director Frank H. NewellAddress Pikesville-8, Md.19. 9-15- 48 E.E. Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1948, at 2- P. M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 25, 1947, to Sept. 13, 1948, and that I last saw her alive on Sept. 10, 1948Immediate cause of death Coronary Thrombosis DURATION SuddenDue to Chronic Myocarditis 2 yrs.Due to Arterio Sclerosis ?Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E.E. Michael M. D. or otherAddress Pikesville-8, Md. Date signed 9-15-48

RECEIVED
SEP 16 1948
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. See correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

House in the Pines, 16 Tristingan

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 509 Old Orchard Rd. Tr
(If rural, give LOCATION)2.(a) If veteran, name war Shells

3. (a) FULL NAME

John Logan Bluncan

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 10, 1883

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

65417

hrs.

min.

9. Birthplace

Kentucky
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

C. & P. Telephone Co

12. Name

Robert Bluncan

13. Birthplace

Indiana

14. Maiden name

Margaret E. Mulloy

15. Birthplace

Ireland

18. Informant

Miss Mary E. Bluncan

Address

509 Old Orchard Rd

17. Burial

Oct. 1, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lorraine Pk.

Location

Woodlawn, Ind.

18. Funeral director

Harvey A. Witzke

Address

4101 Edmondson Ave.

9/30

19. 1948

(Date rec'd by registrar)

1948

R.W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27/48. 19 48, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 13 19 48, to Sept. 27 19 48and that I last saw him alive on Sept. 27 19 48

Immediate cause of death

Heart Failure

DURATION

3 Wks

Due to

Myocardial Infarction

Due to

Coronary Occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? SIGNATURE H. Wasserman

M. D. or other

Address 1501 Eutaw Place Date signed 9-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09140

XX

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1415 Poplar Grove St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-1

3. (a) FULL NAME

ROBERT E. ELLENBERGER

3. (b) Social Security Number

u. 220-09-6330

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Myrtle Ellenberger
 6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) October 12, 1886
 8. AGE: Years 61 Months 10 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Fair Hope, Pa.
 (Town, county, and state)

10. Usual occupation lineman

11. Industry or business Crown Cork & Seal Co.

12. Name Michael Ellenberger

13. Birthplace Pa.

14. Maiden name Manda Philson

15. Birthplace Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial 9/11/48
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Lorraine Park Cemetery

Location Woodlawn, Md.

18. Funeral director Wm. J. Tickner

Address North & Penna. Aves. Balto. Md.

19. 9/8 xx R.W. Hedrich
 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 19 48 at 12:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 48 to September 7 19 48 and that I last saw him alive on September 7 19 48

Immediate cause of death CEREBRAL VASCULAR ACCIDENT DURATION 9 days

Due to Arteriosclerosis

Due to _____

Other conditions Diabetes Mellitus 8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None

_____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE H.C. MANAUGH, M.D., CHF. PRO. SER. M. D. or other

Address VAH FT. Howard, Md. Date signed 9-7-48

CERTIFICATE OF DEATH

Form approved.
Budget Bureau No. 48-R375.

BIRTH NO.

STATE OF

Maryland

STATE FILE NO.

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN Catonsvillec. LENGTH OF
STAY (In this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE

Maryland

b. COUNTY

c. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN Baltimored. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Rev. A. Opitz Homed. STREET ADDRESS (If rural, give location)
3342 Virginia Avenue3. NAME OF DECEASED
(Type or Print)

a. (First)

MARGARET

b. (Middle)

B.

c. (Last)

EMMART

4. DATE OF DEATH

(Month) (Day) (Year)
Sept. 30 1948

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

May 15, 1873

9. AGE (In years last birthday)

75

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Springfield, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Adams

14. MOTHER'S MAIDEN NAME

Malinda Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no16. SOCIAL SECURITY NO.
no

17. INFORMANT

Mr. Grover C. Emmart, 3342 Virginia Ave.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE

(Specify)

no

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. CITY, TOWN, OR TOWNSHIP

(COUNTY)

(STATE)

21d. TIME OF INJURY

(Month) (Day) (Year) (Hour) (Min.)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1948, to Sept 30, 1948, that I last saw the deceased alive on Sept 30, 1948, and that death occurred at 6 P. M., from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

24b. DATE

10/2/48

24c. NAME OF CEMETERY OR CREMATORY

Methodist Ch. Cem.

24d. LOCATION (City, town, or county)

Fort Ashbey

(State)

W. Va.

DATE REC'D BY LOCAL REG.

10/1/48

REGISTRAR'S SIGNATURE

A. W. Hedgcock

25. FUNERAL DIRECTOR

ADDRESS

WILLIAM J. TICKNER & SONS

Balto., Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09142

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. Graybrook Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Ernest Fisher, Jr.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 27, 1948

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2 hrs.

min.

9. Birthplace

Owings Mills, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Charles Ernest Fisher

13. Birthplace

Owings Mills, Md.

14. Maiden name

Dolores Moat

15. Birthplace

Owings Mills, Md.

16. Informant

Dolores Moat

Address

Owings Mills, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Sept. 28, 1948
(month) (day) (year)

Cemetery or crematory

Reisterstown

Location

Reisterstown, Md.

18. Funeral director

William Berryman & Sons

Address

Reisterstown, Md.

19.

9-28-48
(Date rec'd by registrar)

19-48

Mary B. Eline

Registrar

MEDICAL CERTIFICATION

2B. DATE OF DEATH

Sept. 271948at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/271948to 9/271948

and that I last saw him

alive on

9/271948

Immediate cause of death

Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Martin E. Gortel

M. D. or other

Address

Reisterstown, Md.Date signed 9/27/48

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

54. SIGNATURE OF INTERVIEWER

55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

58. SIGNATURE OF INTERVIEWER

59. SIGNATURE OF INTERVIEWER

60. SIGNATURE OF INTERVIEWER

61. SIGNATURE OF INTERVIEWER

62. SIGNATURE OF INTERVIEWER

63. SIGNATURE OF INTERVIEWER

64. SIGNATURE OF INTERVIEWER

65. SIGNATURE OF INTERVIEWER

66. SIGNATURE OF INTERVIEWER

67. SIGNATURE OF INTERVIEWER

68. SIGNATURE OF INTERVIEWER

69. SIGNATURE OF INTERVIEWER

70. SIGNATURE OF INTERVIEWER

71. SIGNATURE OF INTERVIEWER

72. SIGNATURE OF INTERVIEWER

73. SIGNATURE OF INTERVIEWER

RECEIVED

OCT 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09143

CERTIFICATE OF DEATH

Reg. Dist. No. 37

I. PLACE OF DEATH:

County Balto
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Balto
 City or town Sparks (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Western Pine Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Sally Cole Fowble

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife William Fowble

7. Birth date of deceased (mo., day, yr.) Mar. 31 1910 8. (c) If alive, give age 36 years

8. AGE: Years 78 Months 5 Days 9 If less than one day hrs. min.

9. Birthplace Balto Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Alfred Cole

13. Birthplace Balto Co. Md.

14. Maiden name Marcus Babish

15. Birthplace Balto Co. Md.

16. Informant Geo. B. Cole

Address 2927 Westwood Ave Balto

17. Burial Date thereof Sept. 12 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Black Rock

Location Battle Balto Co. Md.

18. Funeral director Samuel M. Brooks

Address Sparks, Md.

Sept. 11, 48 Wilmer C. Ensor

19. (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 48 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 36 to Sept 9 19 48
 and that I last saw him alive on Sept 8 19 48

Immediate cause of death Myocarditis DURATION 2 yrs

Chronic decompensated

Due to hypertension

Due to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. Saffell M. D. or other

Address Disturbance, Md. Date signed 9-9-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09144

1. PLACE OF DEATH

County BaltimoreVillage or City Lutherville

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Betty Katherine Fox

(a) Residence: No.

Lutherville

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

Nov. 30, 1921

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.26915

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

Chicago, Ill.

FATHER

13. NAME

Marbury B. Fox

14. BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

MOTHER

15. MAIDEN NAME

Florence Hilgartner

16. BIRTHPLACE (city or town) (State or country)

Towson, Md.

17. INFORMANT (Address)

M. B. Fox
Lutherville, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Greenmount Cem. Date Sept. 17, 1948

19. UNDERTAKER (Address)

Samuel M. Brooks
Sparks, Md.20. FILED 9-15- 19 48 Wilmer C. Ensor
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Sept

(Month)

15

(Day)

48

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

July19 46

to

Sept19 48I last saw him alive on 14 Sept, 19 48; death is saidto have occurred on the date stated above, at 5 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Encephalitis lethargica

Date of onset

June 48

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Charles H. Reier

M. D.

(Address) 6701 York Rd. Balt. 12, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Chronic interstitial nephritis

Cerebral hemorrhage

Date of onset

1915

1921

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Run over by street car

Peritonitis

Date of onset

1 week ago

1 week ago

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09145

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
 City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

205 Detroit Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore

City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Detroit Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Gerhart

3. (b) Social Security Number

4. Sex

m.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

m.

6. (b) Name of husband or wife

Beatrice M. Gerhart

7. Birth date of

deceased (mo., day, yr.)

April 22, 1900

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

48429

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Blowing Mill Roller

11. Industry or business

Pittsburgh Steel Co.

FATHER

12. Name

William

13. Birthplace

Md.

MOTHER

14. Maiden name

Bertha

15. Birthplace

Pennsylvania

16. Informant

Beatrice M. Gerhart

Address

205 Detroit Ave., Dundalk, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 23, 1948
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern Blvd.

18. Funeral director

Roland P. Fisher

Address

2112 Dundalk Ave., Dundalk

19.

(Date rec'd by registrar)

Sept 23 1948William M. Fisher

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 20

19

48

at

8:15 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Coronary Occlusion

DURATION

5 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

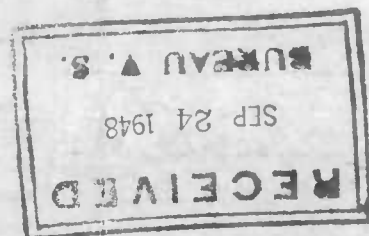
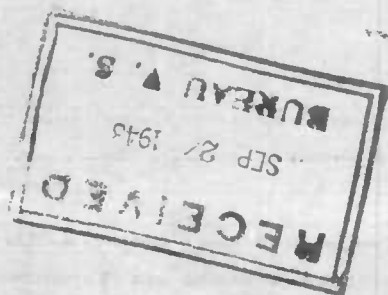
M. J. Davis M.D.

Address

Dundalk, Md.

Date signed

9/22/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09146

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

9 Dungarrie Rd.

Slay in hospital or inst. (yrs., or mos., or days) _____

Slay in this community (yrs., or mos., or days) 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)Street No. 9 Dungarrie Rd.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Clyde E. Good

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife Euphemia Good

8 (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) May 9, 1904

8. AGE:

Years

44

Months

3

Days

25

If less than one day

_____ hrs. _____ min.

9. Birthplace N. J.

(Town, county, and state)

10. Usual occupation Manager11. Industry or business Personal Finance Co.12. Name Robert H. Good

13. Birthplace _____

14. Maiden name Mae Edridge

15. Birthplace _____

16. Informant Mrs. Euphemia Good,Address 9 Dungarrie Rd. Catonsville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 7/48.

(month) (day) (year)

Cemetery or crematory Woodlawn

Location

Woodlawn, Md.18. Funeral director Harry A. LutzkeAddress 4101 Edmondson Ave.19. 9-7

(Date rec'd by registrar)

19 48V.E. Harvey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1948, at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15 1946, to Sept. 4 1948and that I last saw him alive on August 29 1948

Immediate cause of death

Acute Coronary Thrombosis

DURATION

1 hr.Due to Coronary Thrombosis andArteriosclerosis4 yr. (?)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William K. Jellison M.D.

M. D. or other

Address Catonsville, Md. Date signed 9-4-48

MARGIN RESERVED FOR BINDING

V9-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09147/28

1. PLACE OF DEATH:

County Baltimore,City or town Towson,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

Presbyterian

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore,City or town Towson,

(If outside city or town limits, write RURAL and give nearest town)

Street No. Presbyterian Home

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lulu Lee Gordon

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow6.(b) Name of husband or wife Harold L. Gordon

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 18668. AGE: Years 82 Months 4 Days 29 If less than one day hrs. min.9. Birthplace Louisville, Ky.
(Town, county, and state)10. Usual occupation none

11. Industry or business

FATHER 12. Name Oscar Board13. Birthplace Brendenberg, Ky.MOTHER 14. Maiden name Elizabeth E. Clark15. Birthplace Md.16. Informant Mrs. T. E. Elliott Supt.Address Presbyterian Home Towson, Md.17. Burial Date thereof 9/25/1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Pikesville, Md.18. Funeral director John O. Mitchell Sons IncAddress 1900 Eutaw Place Balto. Md.19. Sept 24 19 48 W. Carroll Van Horn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 19 48 at 5 P.M. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 48 to Sept 22 19 48and that I last saw her alive on Sept 22, 19 48

Immediate cause of death

DURATION

Atherosclerosis 4 yrsDue to arteriosclerosisDue to a hypertension 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

Heart failure MD23. SIGNATURE W. Carroll Van Horn M. D. or otherAddress Towson - 4 md Date signed 9/24/48

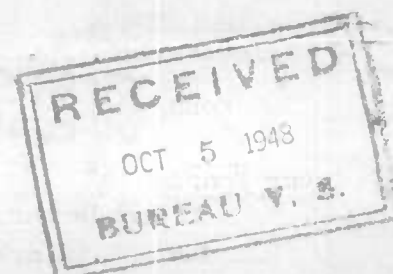
MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTESIAN LEO
BAS CONTENT



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09148

1. PLACE OF DEATH:

County Baltimore
City or town 2900 Onyx Ave. Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Baltimore
City or town 2900 Onyx Ave. Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edith Ross Green

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elmer R. Green

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 7, 1878

8. AGE:

Years

Months

Days

If less than one day

70

9

18

hrs.

min.

9. Birthplace

Ontario Canada

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Solomon Dawson

13. Birthplace

Canada

MOTHER

14. Maiden name

Mary Hannah Quirk

15. Birthplace

Canada

16. Informant

Elmer R. Green

Address

2900 Onyx Ave. Parkville Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 29, 1948
(month) (day) (year)

Cemetery or crematory

Garrettsville

Location

Garrettsville Md.

18. Funeral director

Martin G. Kuntz

Address

Garrettsville Md.

19. Date rec'd by registrar

Oct 26 1948

A. H. Bacon

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 25, 1948 at 10:20 P.M.

21. I CERTIFY that death occurred at the date above stated; that I attended deceased from

home 19 to 19

and that I last saw him

alive on Sept. 25, 1948

Immediate cause of death

Heart disease, possibly coronary, with occlusion

DURATION

Sudden

Due to

Arteriosclerosis

Unknown

Due to

Other conditions

Hypertension

1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Hudson MD DME.

M. D. or other

Address

Towson Md.

Date signed

9/26/48

MARGIN RESERVED FOR BINDING

I

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Colgate
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Baltimore
 City or town..... Colgate
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box 426 Oriole Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Catherine Grim
 7. Birth date of deceased (mo., day, yr.)..... June 29 1875 8. (c) If alive, give age..... 68 years
 8. AGE: Years..... 23 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Berwyn
(Town, county, and state)

10. Usual occupation.....

11. Industry or business..... Butcher12. Name..... John Grim13. Birthplace..... Berwyn14. Maiden name..... Don't know15. Birthplace..... Berwyn16. Informant..... Catherine GrimAddress..... Box 426 Oriole Ave. Baltimore17. Burial Date thereof..... Oct 1 - 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... Holy Redeemer ChurchLocation..... City18. Funeral director..... Funeral HomeAddress..... 2008 Orleans St.19. 10-1 48 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 28 1948 at 9:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1st 1948 to Sept. 28 1948and that I last saw him..... alive on Sept. 28 1948

Immediate cause of death.....

Carcinoma of BladderDuration..... 2 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... no

Date of op.....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... James F. White, M.D.422 Eastern Ave M. D. or otherBaltimore 21, Md Date signed..... 10/1/48

1948
73
1873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

8.(c) If alive give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5751

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 78 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 78 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 432 Fawcett Street
(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

3. (a) FULL NAME

NEILSON M. HALL

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife Divorced

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-93

8. AGE:

Years

Months

Days

It less than one day

5568

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER

12. Name

George Hall

13. Birthplace

Baltimore, Maryland

14. Maiden name

Elizabeth Orem

15. Birthplace

Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial
(Burial, cremation, or removal, Which?)

Date thereof

9/7/48
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Rd. Balto. Md.

18. Funeral director

Address

19. 9/7
(Date rec'd by registrar)18. 48R.W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1948 at 4:10 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 17 1948 to Sept. 3 1948and that I last saw him alive on September 3 1948

Immediate cause of death

METASTATIC CARCINOMA OF LUNGS,
LIVER, KIDNEYS, AND BONE PRIMARY
XXX SITE UNKNOWN

DURATION

UNKNOWN

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J. J. Rittmeyer Injured at work?23. SIGNATURE J. J. RITTMEYER, M.D.

M. D. or other

Address Vah Ft. Howard, Md Date signed 9-11-48

(1949 Revision of Standard Certificate)
CERTIFICATE OF DEATH

Form approved.
Budget Bureau No. 68-R375.

BIRTH NO.		STATE OF		STATE FILE NO.	
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Maryland b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Catonsville-28				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baltimore	
d. FULL NAME OF HOSPITAL OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS (If rural, give location) 719 Northern Parkway	
3. NAME OF DECEASED (Type or Print)		a. (First) Mary		b. (Middle) V.	
		c. (Last) Hardy		4. DATE OF DEATH (Month) (Day) (Year) September 29, 1948	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH June 4, 1868	9. AGE (In years last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Ellis Jordan				14. MOTHER'S MAIDEN NAME Mary E. Lutz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records, Catonsville-28, Maryland	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal pneumonia					
INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.					
ANTECEDENT CAUSES					
DUE TO (b) Central nervous system lues					
DUE TO (c) Hypertensive cardiovascular disease with generalized arteriosclerosis					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION -					
19b. MAJOR FINDINGS OF OPERATION -					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Catonsville-28, Baltimore Maryland	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 25 , 19 48 to September 29 48 , that I last saw the deceased alive on Sept. 29 , 19 48 , and that death occurred at 12:30 p. m., from the causes and on the date stated above.					
23a. SIGNATURE Abraham Schneidmuhl, M.D.				23b. ADDRESS Catonsville-28, Maryland	
23c. DATE SIGNED 9-29-48					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/2/48		24c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
				24d. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REG. 9-30-48		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.	
NORTH AVE. & BROADWAY					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH: County..... <u>Balto.</u> City or town..... <u>Emporium</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md.</u> County..... City or town..... <u>Balto.</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>21 McCormick Ave.</u> (If rural, give LOCATION) <u>(OVERLEA)</u> 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Mary S. Hartline</u>				3. (b) Social Security Number <u>218-22-6860</u>			
4. Sex <u>F.</u>		5. Color or race <u>W.</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife. <u>Frederick L.</u>				6. (c) If alive, give age. <u>56</u> years			
7. Birth date of deceased (mo., day, yr.) <u>March 20 1892</u>				8. AGE: Years <u>56</u> Months <u>6</u> Days <u>7</u> It less than one day <u>hrs.</u> <u>min.</u>			
9. Birthplace. <u>Balto.</u> (Town, county, and state)				10. Usual occupation. <u>At Home</u>			
11. Industry or business. <u>Philip Reinemer</u>				12. Name. <u>German</u>			
13. Birthplace. <u>Theresa Fischer</u>				14. Maiden name. <u>Balto.</u>			
15. Birthplace. <u>Frederick L. Hartline</u>				16. Informant. <u>21 McCormick Ave.</u>			
17. BURIAL (Burial, cremation, or removal. Which?) Cemetery or crematory..... <u>PARKWOOD CEMETERY.</u> Location..... <u>3310 TAYLOR AVE</u> <u>THE DIPPEL BROS</u> Address..... <u>7110 BELAIR RD.</u>				18. Funeral director. <u>Sept 28, 48</u> <u>R. W. Helms</u> (Date read by registrar) Registrar			
20. DATE OF DEATH. <u>Sept 27 1948</u> at <u>7: A.</u> M.				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>February 1 1942</u> to <u>September 27 1948</u> and that I last saw him alive on <u>9-20 1948</u> Immediate cause of death..... <u>Metastatic CARCINOMA</u> <u>CARCINOMA OF CERVIX</u> <u>OF UTERUS</u> Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... <u>CARCINOMA OF CERVIX UTERI</u> <u>(DR. JOHN J. ERWIN)</u> Date of op. <u>Sept 1943</u> Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?				23. SIGNATURE. <u>J. Wm. Machen md.</u> M. D. or other Address..... <u>6321 Belair Rd - 6</u> Date signed <u>9/27/48</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

09153

1. PLACE OF DEATH:

County... BALTIMORE
 City or town... CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... APPROX 1 MO
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... BALTIMORE
 City or town... CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 WYNDCREST AVE
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

MARY R HAUPT

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

late

7. Birth date of

deceased (mo., day, yr.)

AUGUST 4, 1886

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6811

hrs.

min.

9. Birthplace

VIRGINIA

(Town, county, and state)

10. Usual occupation

UNEMPLOYED

11. Industry or business

MOTHER FATHER

12. Name

PETER C MYERS

13. Birthplace

VIRGINIA

14. Maiden name

VIRGINIA CRIDLER

15. Birthplace

MARYLAND

16. Informant

MRS FRANK WALL

Address

3 WYNDCREST AVE

17.

(Burial, cremation, or removal. Which?)

BURIAL

Date thereof

SEPT 8, 1948
(month) (day) (year)

Cemetery or crematory

NEW CATHEDRAL

Location

OLD FREDERICK AD

18. Funeral director

Harry H Witke

Address

4101 Edmonson Ave

19.

(Date received by registrar)

19

8/848AWHedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

SEPT 5 19 48 at 240 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 3 19 48 to Sept 5 19 48

and that I last saw him alive on

Sept 4 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Due to

Other conditions

Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James W. Katzenberg

M. D. or other

Address

77 Medical Center

Date signed

9/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09155

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. 5202 Gwyndale Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (a) FULL NAME

JEHU H. HAYNIE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Bessie

7. Birth date of deceased (mo., day, yr.)

September 2, 1860

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

88013

hrs.

min.

9. Birthplace

Northumberland Co. Virginia

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

J. R. Watkins Co.

MOTHER FATHER

12. Name

Jehu H. Haynie

13. Birthplace

Virginia

14. Maiden name

Elizabeth ?

15. Birthplace

Virginia

16. Informant

Mrs. Bessie Johnston

Address

5202 Gwyndale Avenue

17. Removal (Burial, cremation, or removal. Which?)

RemovalDate thereof Sept. 17, 1948
(month) (day) (year)

Cemetery or crematory

Roseland Cemetery

Location

Reedsville, Virginia

18. Funeral director

William Cook, Inc.

Address

1217 St. Paul Street19. Sept 17 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14th 1948 at 6:45 P.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 13th 1948 to Sept. 14 1948
and that I last saw him alive on Sept. 13th 1948

Immediate cause of death

(1) - Arteriosclerosis - Heart Disease

DURATION

10 yrs.?

Due to

Due to

Other conditions

Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE

Carl D. Chambers

M. D. or other

Address 4108 Liberty St. Date signed 9/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

872

09156

33

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? 17 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Osborne Dunlap Heard.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) March 31, 1926
 8. AGE: Years 22 Months 5 Days 6 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation None

11. Industry or business

FATHER 12. Name Osborne O. Heard
 13. Birthplace Maryland
 MOTHER 14. Maiden name Mary Dunlap
 15. Birthplace Virginia

16. Informant Hospital Records
Rosewood St. Tr. School.

17. Cremation Date thereof Sept 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory London Park

Location Gen. M. T. Smith
 19. Funeral director 811 N. Wolfe St.
9/8 Dr. A. W. Heard
 Address Dr.

19. (Date rec'd by registrar) 19 9/8 Dr. A. W. Heard
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 19 48 at 4 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6, 19 48, to Sept. 7 19 48,
 and that I last saw him alive on Sept. 7 19 48.
 Immediate cause of death Bronchopneumonia

DURATION

4 days

Due to
 Due to

Other conditions Grand mal epilepsy 21 plus
Congenital spastic diplegia yrs.
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Md. Injured at work? Balto.

23. SIGNATURE W. B. Johns M.D.
 M. D. or other
 Address Rosewood St. Tr. School Date signed 9/7/48

CERTIFICATE OF DEATH

Belco.

Mr. Owinga Mills

September 7 48 A.P.M.

Sept. 6, 48
Sept. 7, 48
Sept. 7, 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09157

Reg. Dist. No.

48

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Whittemarsh
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 473
(If rural, give LOCATION)
2. (a) If veteran, name war WW 1

3. (a) FULL NAME

HARRY A HELF SR

3. (b) Social Security Number

109-05-3391

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Freida Helf
6. (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) June 11, 1898
8. AGE: Years 50 Months 3 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace New York City, New York
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business _____

FATHER 12. Name John Helf, dec.
13. Birthplace New York
MOTHER 14. Maiden name Christine Larenze
15. Birthplace New York

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 9/16/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland

18. Funeral director Howard Blight
Address 6009 Bayford Road Baltimore, Md.

19. Sept 16 19 48 A. W. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 19 48 at 5:10 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 19 48 to Sept. 13 19 48
and that I last saw him alive on Sept. 13 19 48

Immediate cause of death Chr. Nephritis DURATION Unknown

Due to Unknown

Due to _____

Other conditions Extreme hypertrophy of heart with failure Due to: Chr. Nephritis Unknown
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, pub'c place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE H.C. MANAUGH M. D. or other H.C. MANAUGH, M.D. Chief Pro. Ser.
Address VAH, Ft. Howard, Md. Date signed 9-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Whitenarsh, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Whitenarsh, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Ebenezer Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

AMANDA HOLTZNER.

3.(b) Social Security Number

215-03-1621

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife William Holtzner

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 18th, 1885

8. AGE: Years Months Days If less than one day

62 10 20 _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business Wight Distillery12. Name Edward Beares13. Birthplace Baltimore County, Md.14. Maiden name Lizza J. Blakeley15. Birthplace Baltimore County, Md.16. Informant Mrs. Hazel CollinsAddress 5003 Crosswood Ave.17. burial Date thereof 9/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fork MethodistLocation Fork, Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Rd.19. 9/10/48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 19 48 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 26 19 43 to June 29 19 48and that I last saw him alive on June 29 19 48

Immediate cause of death

Cerebral Haemorrhage

DURATION

2 hrs?

Due to

Hypertensive Cardiovascular disease10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ray J. Miller M. D. or otherAddress Ray Rd, Baltimore - 6 Date signed Sept 8/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09158

RECEIVED
SEP 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09159

Reg. Dist. No. 38

1. PLACE OF DEATH
County Baltimore
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
Broadway Road
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Broadway Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Florence E Hood 3. (b) Social Security Number —

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Atis Hood
7. Birth date of deceased (mo., day, yr.) 1861
8. AGE: Years 87 Months — Days — If less than one day — hrs. — min. —
9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation at home
11. Industry or business —

MOTHER FATHER
12. Name — (?)
13. Birthplace — (?)
14. Maiden name Whiting
15. Birthplace — (?)

16. Informant Mrs Hood
Address Broadway Rd. Lutherville
17. Burial Date thereof 9-23-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location —

18. Funeral director Wedgfeld & Son
Address Greenmount Ave. & 22nd St
9/22/48 SW Hedrick
(Date rec'd by registrar) 19. — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1948 at 945 A. M.
21. I CERTIFY the death occurred on the date above stated; that I attended deceased from Sept 5 1948 to Sept 20 1948
and that I last saw him alive on Sept 19 1948
Immediate cause of death Heart disease, chronic
myocarditis DURATION 2 yrs.
Due to Senile changes with arteriosclerosis 10 yrs +
Due to —
Other conditions Cellulitis left neck 6 days.
(Include pregnancy within 8 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?
23. SIGNATURE Rollin C. Hudson M.D. M. D. or other
Address Towson Md Date signed 9/20/48.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

09160

33

1. PLACE OF DEATH:

County BaltimoreCity or town Peisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Int. Pleasant AnatomumHow long in hospital or institution? 7 years + 4 months

3. (a) FULL NAME

Beatrice Horner

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas Horner

7. Birth date of

deceased (mo., day, yr.) December 27, 1899

6. (c) If alive, give age _____ years

8. AGE:

Years 48 Months 8 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace

Prussia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER

12. Name Hymen Denneburg13. Birthplace Prussia14. Maiden name Rose Silverman15. Birthplace Prussia16. Informant Mrs. Marie HorneAddress 2028 Eastern Ave., Balt. Ind.17. Burial Date thereof Sept. 24, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oheb Shalom Cem.Location O'Donnell St.18. Funeral director Sol Levinson & BrosAddress 1124-1126 W North Ave19. 9/24 48 Edw. Hedrich Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2028 Eastern Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948 at 4 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 1941 to Sept. 23, 1948and that I last saw him alive on Sept. 23, 1948

Immediate cause of death

Myocardial Failure

DURATION

2 weeks20 years20 years36 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cardiovascular General Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. Pruner MD.Address Peisterstown, Ind. Date signed Sept. 23, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

09161

93d

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
120 Maiden Choice Lane
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120 Maiden Choice Lane
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Annie Hoffman Houghton

3. (b) Social Security Number

4. Sex female **5. Color or race** white **6. (a) Single, married, widowed, or divorced** widowed

8. (b) Name of husband or wife Louis S. Houghton

7. Birth date of deceased (mo., day, yr.) January 31, 1869 **6. (c) If alive, give age**..... years

8. AGE: Years 79 Months 2 Days 23 If less than one day..... hrs. min.

9. Birthplace Brownsville, Washington Co., Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Ephriam Nice Warner

13. Birthplace Loudon County, Va.

14. Maiden name Margaret Ann Newcomer

15. Birthplace Hagerstown, Md.

16. Informant Mr. Reuben H. Houghton

Address 127 Spa View Ave., Annapolis, Md.

17. Burial Burial **Date thereof** Sept. 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.

18. Funeral director John C. Whitehead & Sons, Inc.

Address 1900 Eutaw Place, Baltimore 17, Md.

9-24 **19** **48** **10** **2** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 48, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 47 to 23 Sept. 19, 48 and that I last saw her alive on 22 Sept. 19, 48

Immediate cause of death Cerebral occlusion **DURATION** 10 hours

Due to arteriosclerotic hypertensive cardiovascular disease **5 yrs +**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Date of**.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... **Injured at work?**.....

23. SIGNATURE John A. Preston **M. D. or other**

Address 20 E. Preston St., Balto. **Date signed** 24 Sept 48

MARGIN RESERVED FOR BINDING

VS-415 9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

09162

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 438 W. Conway St.
(If rural, give LOCATION)2. (a) If veteran, name war WW-2

3. (a) FULL NAME

MELVIN R. HOUSE

3. (b) Social Security Number

212-01-4938

4. Sex <u>Male</u>	5. Color or race <u>NEGro</u>	6. (a) Single, married, widowed, or divorced <u>Married - separated</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Eva House7. Birth date of deceased (mo., day, yr.) February 22, 1910
6. (c) If alive, give age 35 years

8. AGE: Years <u>38</u>	Months <u>6</u>	Days <u>17</u>	If less than one day hrs. min.
----------------------------	--------------------	-------------------	-----------------------------------

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Robert House13. Birthplace Baltimore, Md.14. Maiden name Wilhemina Henry15. Birthplace Baltimore, Md.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof Sept 13 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Ave. Balto. Md.18. Funeral director Isaiah BrownAddress 108 Montgomery St. Balto. Md.19. 9/11 48 R. W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 19 48 at 9:35 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 48 to Sept. 9 19 48
and that I last saw him alive on September 9 19 48Immediate cause of death PULMONARY TUBERCULOSIS, BILATERAL DURATION 3 yrs.

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul O. Anderson M.D. M. D. or otherAddress VAH FT. Howard, Md. Date signed 9-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09163 38

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred

606 Overbrook Road

How long in hospital or institution?

3. (a) FULL NAME

Harry M. Huether

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Emma A. BerndtHuether 6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) June 11, 18898. AGE: Years 59 Months 3 Days 16 If less than one day hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Secretary, Treasurer11. Industry or business Old Colony Printing Co12. Name Louise Huether13. Birthplace Germany14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Emma A. HuetherAddress 606 Overbrook Rd, Baltimore17. (Burial, cremation, or removal) Which? Burial Date thereof Sept 24, 1948
(month) (day) (year)Cemetery or crematory Forestwood CemLocation Baltimore18. Funeral director Lorris ByersAddress 5005 Park Heights Ave, Baltimore19. 9/29 19 48 G. W. Hedrick
(Date) (by registrar) (year) (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 606 Overbrook Rd
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 19 48 at 10:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 19 43 to Sept 27 19 48and that I last saw him alive on Sept 27 19 48Immediate cause of death Coronary occlusion DURATION 14 hrsDue to Arteriosclerosis 5 yrs.Due to Heart diseaseOther conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of Injury None Injured at work? None23. SIGNATURE A. S. Chalfantony M. D. or other Sept 28, 48Address 6210 York St Date signed Sept 28, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09164

Reg. Diat. No. 138 35 238

1. PLACE OF DEATH:

County... BaltimoreCity or town... Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mo., 14 days

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? 7 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...City or town... Belt
(If outside city or town limits, write RURAL and give nearest town)Street No. Waterfront Hotel
(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (a) FULL NAME

William O. Hunt

3. (b) Social Security Number

243-26-5687

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 2, 1923

8. AGE: Years Months Days If less than one day

25 5 21 hrs. min.

9. Birthplace

Lumberton, N.C.
(Town, county, and state)

10. Usual occupation

Shop yard worker

11. Industry or business

12. Name

Oliver Hunt

13. Birthplace

North Carolina

14. Maiden name

Elizabeth Hammond

15. Birthplace

North Carolina

16. Informant

Personal history—Hospital recordsAddress Eudowood Sanatorium, Towson 4, Md.17. Removal Date thereof Sept. 24, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Biggs Funeral Home

Location

Lumberton, N.C.

18. Funeral director

John Burns' Sons

Address

Towson, Md.19. Sept 23 19 48 W. Carroll Van Horn
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 19 48 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 2 19 48 to Sept 23 19 48and that I last saw him alive on Sept 22 19 48Immediate cause of death Pulmonary TBC

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

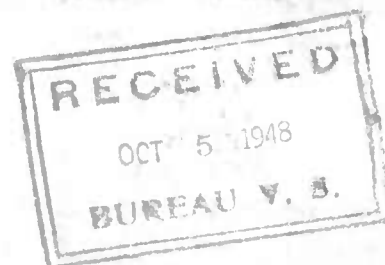
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. DoctorAddress Towson 4, Md. Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09165

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
City or town Owings Mills, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs 10 mos 28 days
Hospital, institution or street address where death occurred: Rosewood
How long in hospital or institution? 26 yrs 10 mos 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County _____
City or town Pelham, Pa (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Bruce Virginia Shanton

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) August 25, 1881 6. (c) If alive, give age _____ years

8. AGE: Years 67 Months 11 Days 0 If less than one day 7 hrs. 0 min.

9. Birthplace Pelham, Pa
(Town, county, and state)

10. Usual occupation Inmate Rosewood

11. Industry or business _____

12. Name Jas. Warner Shanton

13. Birthplace md

14. Maiden name Rachael Price

15. Birthplace md.

16. Informant Institutional Records

Address Rosewood, Owings Mills, Md

17. Burial Date thereof Sept 11-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Friends Burial Ground

Location Baltimore City

18. Funeral director J. F. Elmer - Sons

Address Baltimore Md

19. 9-8-48 Mary B. Elmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept 48 at 7 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 48 to 6 Sept 19 48
and that I last saw him alive on 6 Sept 19 48

Immediate cause of death _____ DURATION _____

Adeno-Carcinoma of Ovary with Metastasis to Ovary 5 mos

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations See above

Date of op. 8/2/48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE H. B. Byler M. D. or other _____

Address Owings Mills, Md Date signed 6 Sept 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1948

BUREAU V. S.

(1949 Revision of Standard Certificate)
CERTIFICATE OF DEATH

Form approved 09166
Budget Bureau No. 68-R375.

BIRTH NO.		STATE OF		STATE FILE NO.	
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Maryland b. COUNTY Balto	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Catonsville		c. LENGTH OF STAY (In this place) since 6/10/1948		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baltimore	
d. FULL NAME OF HOSPITAL OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 1814/Fayette St.	
3. NAME OF DECEASED (Type or Print) Anna		a. (First) Virginia		c. (Last) JACKSON	
4. DATE OF DEATH September 26, 1948		5. SEX F F		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 3-25-1876		9. AGE (In years last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming house manager		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James G. Parsons		14. MOTHER'S MAIDEN NAME Mary Fratis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) C. N. S. lues DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 5 days indef.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6/10/1948 , 19__, to 9/26/1948 , 19__, that I last saw the deceased alive on 9/25/1948 , 19__, and that death occurred at 5:40 A.m. , from the causes and on the date stated above.					
23a. SIGNATURE Abraham M. Schneidmuhl, M.D.		23b. ADDRESS Spring Grove Hospital		23c. DATE SIGNED 9/26/1948	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/29/48		24c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	
24d. LOCATION (City, town, or county) Balto., Md.		25. FUNERAL DIRECTOR WM. J. TICKNER & SONS		ADDRESS Balto., Md.	
DATE REC'D BY LOCAL REG. 9/28/48		REGISTRAR'S SIGNATURE Carl Heinrich			

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **167**

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Ft. Howard Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) **10 hrs.**

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State **Md.**

(b) County.....

(c) City or town **Balto.,**

(If outside city or town limits, write RURAL and give town)

(d) Street No..... (If rural give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME

LEDUS JENKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced. **Single**

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1920

8. AGE:

Years

Months

Days

If less than one day

28

hr.

min.

9. Birthplace

Washington, N.C.

(Town, county, and state)

10. Usual Occupation

Laborer

11. Industry or business

FATHER

12. Name

Solomon Jenkins

13. Birthplace

N. C.

MOTHER

14. Maiden Name

Emily ?

15. Birthplace

N. C.

16 (a) Informant

Wm. McCabe

(b) Address

215 Sharp Street

17 (a) **Shipped**

(b) Date thereof **9-22-48**

(Partial cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Washington, N.C.

Location **A. Halstead**

918 Druid Hill Avenue

18 (a) Funeral director

(b) Address

19 (a) **9/22/48** (b) **Dr. H. L. Halstead**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 19, 1948**, at **2:02 P.M.**

21. I certify that I took charge of the remains described above, held an

Autopsy

thereon and from the evidence obtained

Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

his

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐.

homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

**Hemorrhage due to steel
wound of neck**

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was **primary** ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public

place?..... While at work?

(d) Means of injury

23. Signature

Medical Examiner

M.D.

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **EX**

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

309 Arundel RdHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 309 Arundel Rd
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Theodore Roosevelt Johnson

3. (b) Social Security Number

4. Sex M5. Color or race Colored6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Betty Green Johnson6. (c) If alive, give age 38 years7. Birth date of deceased (mo., day, yr.) June 12, 19048. AGE: Years 44 Months 3 Days 13 If less than one day
.....hrs.10 min.9. Birthplace Bulluck, N.C.
(Town, county, and state)10. Usual occupation Plumber Helper11. Industry or business Construction Co.12. Name Stalter P. Johnson13. Birthplace Bulluck, N.C.14. Maiden name Marye Morton15. Birthplace Bulluck, N.C.16. Informant Albert JohnsonAddress 515 New Pittsburgh Ave17. Cause Bone Date thereof Sept. 26, 1948Burial, cremation, or removal Shilo Baptist ChurchCemetery or crematory Of Ford N.C.Location Choy O'Wilson18. Funeral director Choy O'WilsonAddress 1000 Brantley St.19. 9/27 (Date rec'd by registrar) 19 Registrar Stalter P. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1948 at 12:30 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19, 1948 to September 23, 1948 and that I last saw him alive on September 23, 1948Immediate cause of death Bronchial Pneumonia

DURATION

4 daysDue to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Stalter P. Johnson, M.D.

M. D. or other

Address 140 Oak Ave Date signed 9-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ^{Be} correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ⁴⁴ ~~44~~

09170

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1609 W. Lanvale St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW I ✓

3. (a) FULL NAME

WILLIAM H. JOHNSON

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Widowed
 7. Birth date of deceased (mo., day, yr.) June 17, 1888 6. (c) If alive, give age _____ years
 8. AGE: Year 60 Month 2 Day 22 If less than one day _____ hrs. _____ min.

9. Birthplace Richmond, Virginia
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name Aaron Johnson
 13. Birthplace Virginia
 14. Maiden name Mary Williams
 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland
 17. Burial Date thereof 9/11/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Md.
 18. Funeral director Charles R. Law
 Address 802 Madison Ave., Balto., Md.

19. Sept 11 48 William M. Kelly Jr.
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 19 48 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 19 48 September 9 19 48 and that I last saw him alive on September 9 19 48

Immediate cause of death CARDIAC DILATATION AND HYPERTROPHY DURATION Unknown

Due to _____

Due to _____

Other conditions Pulmonary Tuberculosis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated Above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. M. Kelly Jr. M. D. or other _____Address VAH Fort Howard, Md. Date signed 9-10-48



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09171

30

1. PLACE OF DEATH:

County **Baltimore**
 City or town **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **2 months, 22 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **2 months, 22 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County
 City or town **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Seton Institute**
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary B. Kelly

3. (b) Social Security Number

4. Sex **female** 5. Color or race **white** 6. (a) Single, married, widowed or divorced **single**

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **May 10, 1866** 6. (c) If alive, give age years

8. AGE: Years **82** Months **3** Days **27** If less than one day hrs. min.

9. Birthplace **Baltimore, Maryland**
 (Town, county, and state)

10. Usual occupation **None**11. Industry or business **None**12. Name **Hugh Kelly**13. Birthplace **Ireland**14. Maiden name **Mary Hoshall** **Mary E. Hoshall**15. Birthplace **Maryland**16. Informant **Hospital records**Address **Catonsville-28, Maryland**

17. **Burial** Date thereof **Sept. 7/48**
 (Burial, cremation, or removal, which?) (month) (day) (year)
Cathedral

Cemetery or crematory **Baltimore, Md.**Location **Chapel of the Holy Spirit**18. Funeral director **805 North Calvert St. Balto.**Address **9/2** **48** **W. Hedrick**

19. **9/2** **48** **W. Hedrick**
 (Date rec'd by registrar) 19 **48** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 6** 19 **48** at **12:20 a.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 15** 19 **48** to **September 6** 19 **48** and that I last saw him alive on **September 6** 19 **48**

Immediate cause of death **Terminal pneumonia, both bases** DURATION **5 days**

Due to **Hypertensive cardiovascular-renal disease** **Indefinite**

Due to **Arteriosclerosis, generalized** **"**

Other conditions **Arthritis deformans** **"**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **none**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Isadore Tuerk, M.D.** M. D. or otherAddress **Catonsville-28, Maryland** Date signed **9-6-48**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09172

Reg. Dist. No. 38

1. PLACE OF DEATH

County Baltimore
 City or town Rogers' Forge (Towson 4)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
85 Murdock Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Rogers' Forge (Towson 4)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 85 Murdock Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Dorothy Chesher Kenty

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband William Y. Kenty
 7. Birth date of deceased (mo., day, yr.) Jan. 21, 1904
 6. (c) If alive, give age _____ years
 8. AGE: Years 44 Months 8 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Bloomington, Ill.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business At Home
 FATHER 12. Name Pearl Chesher
 13. Birthplace Ill.
 MOTHER 14. Maiden name Jessie Mc Intire
 15. Birthplace Ill.

16. Informant William Y. Kenty
 Address 85 Murdock Rd, Towson 4 Md.
 17. Burial Burial Date thereof Oct 2, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Prospect Hill Cemetery
 Location Towson, Maryland
 18. Funeral director John Burns' Sons
 Address Towson, Maryland
 19. (Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1948 at 11 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____
 Immediate cause of death Heart disease, sudden
with coronary occlusion, sudden
 DURATION Callan
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Bollin C. Hudson M.D. D.M.E.
 M. D. or other _____
 Address Towson Md Date signed 9/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09173

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Maney Kimberly

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Alice Roberts

7. Birth date of deceased (mo., day, yr.)

Aug. 1, 1870

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

78110

hrs.

min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

John Kimberly

13. Birthplace

New York

MOTHER

14. Maiden name

Eliz. Maney

15. Birthplace

North Carolina

16. Informant

Dr. Ral'th Kimberly

Address

Bell Grove Rd

17.

(Burial, cremation, or removal. Which?)

Date thereof

9-13-48
(month) (day) (year)

Cemetery or crematory

London Park Cem

Location

Baltimore

18. Funeral director

George A. Finley

Address

Fuller & Fayette St.

19.

9-13-48

19

48

(Date rec'd by registrar)

W.E. Harris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto.

City or town

Catonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Bell Grove Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 11-1948at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan1940to September 111948and that I last saw him alive on September 10 1948

Immediate cause of death

Cornary Occlusion

DURATION

few days

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.E. Harris

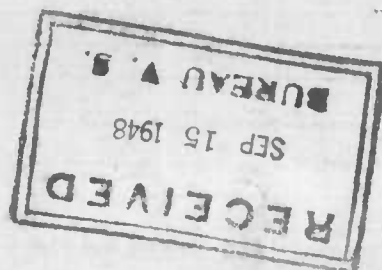
M. D. or other

Address

20 E. Preston St.

Date signed

9/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09174

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
936 Elm Ridge ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 936 Elm Ridge ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ruth E Koehler

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George M
 6.(c) If alive, give age 42 years
 7. Birth date of deceased (mo., day, yr.) Feb 4 1905
 8. AGE: Years 43 Months 6 Days 28 If less than one day
hrs. min.

9. Birthplace Baltimore
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Harry Meeth
 13. Birthplace Baltimore
 14. Maiden name Melburn Keatley
 15. Birthplace Baltimore Md

16. Informant Geo. M Koehler
 Address 936 Elm Ridge ave
 17. Burial Date thereof 9-6-48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Linden Park
 Location Baltimore

18. Funeral director Frederick A Cole
 Address 1200 W Fort Blvd St
 19. Sept 5 48 19 48 Geo Koehler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 48 19 48 at 5-30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 48 to 19 48
 and that I last saw him alive on 19 48

Immediate cause of death Strangulation
hanging
 Due to suicide
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Suicide Date of 9-2-48
 Where did injury occur? Arbutus Baltimore
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) home
 Means of injury from rate pipe Injured at work?
 23. SIGNATURE Geo M Koehler M. D. or other
 Address 1010 Linden Date signed 9-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
VETS. Adm. Hosp. Fort Howard, Md.
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1548 North Gate Rd. Balto. Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name was SAW ✓

3. (a) FULL NAME

GEORGE R. KREPS, George R.3. (b) Social Security Number
unknown

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Edith B. Kreps
 8. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) March 2, 1879
 8. AGE: Years 69 Months 6 Days 23 If less than one day hrs. min.

9. Birthplace Greenville, Pa.
(Town, county, and state)10. Usual occupation retired

11. Industry or business

FATHER 12. Name William Kreps
 13. Birthplace Greenville, Pa.

MOTHER 14. Maiden name Lucetta Taylor
 15. Birthplace Penna.

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Removal Date thereof 9/27/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Castle, Pa. (Oak Park Cem.)
 Location

18. Funeral director William J. Tickner
 Address North & Penna. Aves. Balto. Md.

19. Sept 27 19 48 A.W. Heffrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 19 48 2:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 8 19 48 to Sept. 25 19 48
 and that I last saw him alive on Sept. 25 19 48

Immediate cause of death

CARDIORESPIRATORY FAILUREDURATION
unknownDue to Probable Coronary Thrombosisunknown

Due to

Other conditions Carcinoma of Rectum4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A.E. Pugh, M.D.

M. D. or other

Address VAH FT. Howard, Md. Date signed 9-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09176

Reg. Diat. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)Street No. 7623 Phila Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John L Langerfelder

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Elizabeth Langerfelder

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 18798. AGE: Years 68 Months 11 Days 5 If less than one day hrs. min.9. Birthplace Balto Co
(Town, county, and state)10. Usual occupation farmer (retired)

11. Industry or business

12. Name George Langerfelder13. Birthplace md14. Maiden name Lena Lang15. Birthplace md16. Informant Geo H LangerfelderAddress 7623 Phila Road17. Burial Date thereof Sept 8 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Iron CemLocation Shenandoah Run Md18. Funeral director Wilbur Funeral HomeAddress 2008 Orleans St19. Jan 16 1948 Balto City, Md
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1948 at 11 p M21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 1 1948 to Sept 2 1948and that I last saw him alive on Sept 2 1948Immediate cause of death Cerebral apoplexyDURATION 3 daysDue to arterio-scleroticcardio-vascular disease 2 yrs

Due to

Other conditions diabetes mellitus 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo M. BaumgardnerAddress Balto 6 M. D. or otherDate signed 9-3-48

SEP 7 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09177

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Maude O'Dell Larmore

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Marion A. Larmore6.(c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) Nov. 27, 19088. AGE: Years 39 Months 9 Days 13 It less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name George Edward Jones13. Birthplace Maryland14. Maiden name Mary Alice Crue15. Birthplace Maryland16. Informant Marion A. LarmoreAddress Cockeysville, Md.17. Burial Date thereof Sept. 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Grace Methodist CemeteryLocation Falls Road, Cockeysville, Md.18. Funeral director John Burns, SonsAddress Towson, Md.19. 9 - 11 - 48 Registrar E. E. Pichers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1948 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948 and that I last saw him alive on Sept 3 1948Immediate cause of death Coronary ThrombosisDue to Chronic MyocarditisDue to Arterial HypertensionOther conditions Chronic Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

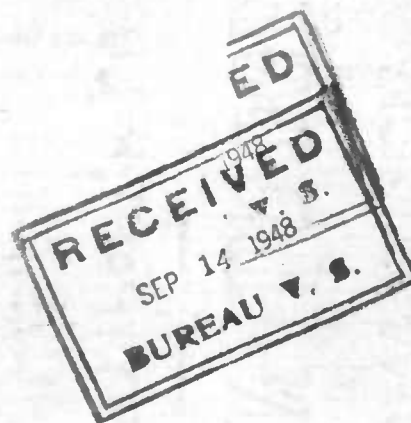
Means of injury _____ Injured at work? _____

23. SIGNATURE E. E. Pichers M. D. or other _____Address Pikesville-8, Md. Date signed 9/11/48

MARGIN RESERVED FOR BINDING

VS 44b

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH
County Balto.
City or town Park Heights Balto C.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7410 Kenleigh Ave
How long in hospital or institution? 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Balto
City or town Park Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7410
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dorothea Marguerite Lewis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Andrew Lewis

7. Birth date of deceased (mo., day, yr.) Feb 27/1864 6.(c) If alive, give age 84 years

8. AGE: 84 Years 6 Months 7 Days If less than one day

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Mr. Lena Robies
13. Birthplace at home

14. Maiden name at home
15. Birthplace at home

16. Informant at home

17. Burial, cremation, or removal, Which? Burial Date thereof Sept 6/48
(month) (day) (year)

Cemetery or crematory Oak Lawn Cem.

Location Balto Md

18. Funeral director Wassah Funeral Home

Address 7401 Belair Rd.

19. Sept. 4 1948 Mrs. C. L. Reynolds
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1948 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 10 10

Immediate cause of death Coronary occlusion

Due to Immediate

Due to Immediate

Other conditions Immediate

(Include pregnancy within 3 months of death)

Major findings of operations Immediate

Date of op. Immediate

Autopsy results Immediate

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Immediate Date of Immediate

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. L. Moore Jr. D.

Address Balto C. Md Date 9/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09179

Reg. Dist. No. 3/

1. PLACE OF DEATH:

County... *Baltimore*City or town... *Granite*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md* County... *Baltimore*City or town... *Granite*
(If outside city or town limits, write RURAL and give nearest town)Street No... *Offutt Rd*
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetary or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Sept 1 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him... alive on... 19...

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

Dist. #2



St. Schenck

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09180

44

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 68 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.
 How long in hospital or institution?..... 68 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Pennsylvania County.....
 City or town..... McSherrytown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... WW-2

3. (a) FULL NAME

RAYMOND P. LITTLE

3. (b) Social Security Number

Unknown

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of deceased's wife..... Catherine Little
 7. Birth date of deceased (mo., day, yr.)..... 4-18-20 8. (c) If alive, give age..... 25 years
 8. AGE: Year..... 28 Month..... 5 Days..... 10 If less than one day..... hrs. min.

9. Birthplace..... McSherrytown, Pa.
 (Town, county, and state)
 10. Usual occupation..... Laborer
 11. Industry or business.....

FATHER 12. Name..... John J. Little
 13. Birthplace..... Pennsylvania
 MOTHER 14. Maiden name..... Mary Smith
 15. Birthplace..... Pennsylvania

16. Informant..... Clinical Records, Vets. Adm. Hosp.
 Address..... Fort Howard, Maryland

17. Removal..... September 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... St. Mary's Cemetery
McSherrytown, Pennsylvania
 Location.....

18. Funeral director..... Joseph T. Kernan
 Address..... McSherrytown, Pennsylvania

19. Sept 29, 1948 Dwight L. Harbo
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 28, 19 48, at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 23, 1948 19 48 to Sept. 28, 19 48

and that I last saw him alive on September 28, 19 48
 Immediate cause of death..... Chronic Nephritis

DURATION..... Unknown

Due to.....

Due to.....

Other conditions..... Infarct rt. Temporal Lobe
of the brain.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

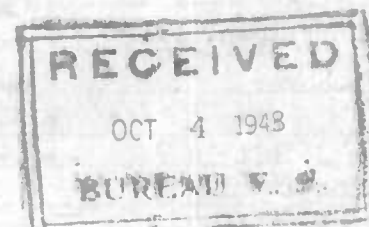
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... P.W. Roman, M.D.

P.W. ROMAN, M.D. M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 7 weeks

3. (a) FULL NAME

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Grace Agnes Lewellyn

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 18 18698. AGE: Years 79 Months 2 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Salesman11. Industry or business William R. Lewellyn12. Name William R. Lewellyn13. Birthplace va14. Maiden name Aurelia Brown15. Birthplace US16. Informant M. Herbert LewellynAddress 3717 Harmon Ave17. Burial, cremation, or removal (Which) Burial Date thereof Sept 19 1948
(month) (day) (year)Cemetery or crematory London Park CemLocation Baltimore, Md.18. Funeral director Epiles LamonianAddress 4510 Liberty Heights Ave19. 9/20 1948 A.W. Hedrich
(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3717 Harmon Ave
(If rural, give LOCATION)

2. (c) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 - 1948 to Sept 18 1948and that I last saw him alive on Sept 15 1948

Immediate cause of death _____

11 - Arterio-scleroticheart - vascular disease

Due to _____

Due to _____

Other conditions Broncho-pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul J. Chambers

M. D. or other _____

Address 4108 Liberty Hts. Ave Date signed Sept 18

DURATION

5 yrs?1 day

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09182

Reg. Dist. No. 44

1. PLACE OF DEATH

County Balto.City or town Gray Manor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Gray Manor
(If outside city or town limits, write RURAL and give nearest town)Street No. 2801 Mc Cormac
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Fannie Carter Lockamy

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John S. Lockamy7. Birth date of deceased (mo., day, yr.) Jan. 12 - 1876

6. (c) If alive, give age _____ years

8. AGE: Years 72 Months 9 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Parkersburg, W. C.
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name Louis Carter13. Birthplace N. Carolina14. Maiden name Fannie McDaniel15. Birthplace N. Carolina16. Informant J. N. LockamyAddress 2801 Mc Cormac, Gray Manor17. Transportation Date thereof Sept. 30 - 1948

(Burial, cremation, or removal. Which?) _____ (month) (day) (year)

Cemetery or crematory Family CemeteryLocation Reeborg, N. Carolina18. Funeral director John S. ConnollyAddress 488 Eastern Ave. Essex19. Sept 30 1948 John S Connolly

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 September 1948, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 June 1948 to 30 Sept 1948and that I last saw him alive on 29 Sept 1948Immediate cause of death Heart Failure

DURATION

Due to Chronic Heart Disease 10 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Dr. Herbert Morrison

M. D. or other _____

Address 2534 YorkwayDate signed 2 Oct. 48



PLEASE WRITE PLAINLY, ~~with~~ UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09183

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 1/2 yrs
 Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville Md
 How long in hospital or institution? 1 1/2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State new jersey County _____
 City or town Maywood N.J.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 125 Park Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Gertrude Foxless

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Nathan C. Foxless
 7. Birth date of deceased (mo., day, yr.) Feb. 22, 1872 6.(c) If alive, give age _____ years
 8. AGE: Years 76 Months 6 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Town Point Md
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____

FATHER 12. Name Wm. F. Pusner
 13. Birthplace Md
 MOTHER 14. Maiden name Mary Jane Canaan
 15. Birthplace Md

16. Informant Laura M. Schroeder
 Address Masonic Home, Cockeysville Md
 17. Burial Date thereof Sept 8, 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bethel Cemetery, Chesapeake
 Location Chesapeake City Md

18. Funeral director Wm. Cook
 Address St. Paul & Preston St

19. Sept 7th 19 48 L. M. Schroeder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 19 48 at 5¹⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 47 to Sept 6 19 48
 and that I last saw him alive on Sept 6 19 48

Immediate cause of death _____ DURATION
Coronary Thrombosis 1 day
 Due to _____
Arterio-sclerosis
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Walter T. Kees M.D.
 Address Cockeysville Md Date signed 9/6/48

RECEIVED

SEP 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 49

1. PLACE OF DEATH:

County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State: Pennsylvania County: _____
City or town: Glenrock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2. (a) If veteran, name war: WW-1

3. (a) FULL NAME

JEREMIAH FLETCHER LUTZ

3. (b) Social Security Number

UNKNOWN

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife: <u>Lottie E. Lutz</u>			
6. (c) If alive, give age: <u>74</u> years			
7. Birth data of deceased (mo., day, yr.) <u>November 25, 1872</u>			
8. AGE: Years <u>75</u>	Months <u>9</u>	Days <u>16</u>	If less than one day hrs. min.
9. Birthplace: <u>Baltimore, Maryland</u> (Town, county, and state)			
10. Usual occupation: <u>physician</u>			
11. Industry or business			
12. Name: <u>unknown</u>			
13. Birthplace: <u>Baltimore, Md.</u>			
14. Maiden name: <u>Mary Richmond</u>			
15. Birthplace: <u>Baltimore, Md.</u>			

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11, 19 48, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31, 19 48, to Sept. 11, 19 48, and that I last saw him alive on September 11, 19 48.

Immediate cause of death	DURATION
<u>Arteriosclerosis, generalized, sev.</u>	<u>2yrs plus</u>
<u>Coronary Arteriosclerosis</u>	<u>2 yrs plus</u>
<u>xxx Cerebral Arteriosclerosis</u>	<u>2yrs plus</u>
Due to	
Due to	
Other conditions: <u>None</u>	
(Include pregnancy within 8 months of death)	
Major findings of operations: <u>none</u>	
Date of op.	
Autopsy results: <u>none</u>	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. (Burial, cremation, or removal, Which?) Burial Date thereof: Sept 14, 1948
(month) (day) (year)
Cemetery or crematory: Union
Location: Glen Rock, Pa.

18. Funeral director: H. C. Seiple
Address: Glen Rock Pa. license

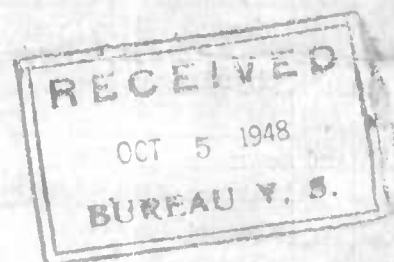
19. Sept. 11, 19 48
(Date rec'd by registrar) Registrar: John H. Connolly

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE: Russell Brandon M.D.
Address: VAH Ft. Howard, Md. Date signed: 9-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09191

Reg. Dist. No. 48

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1200 S. Ellwood Ave.
(If rural, give LOCATION)2. (a) If veteran, name war VVW-1

3. (a) FULL NAME

MIKE MALCZEWSKI

3. (b) Social Security Number

218-01-8003

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

WidowedB. (b) Name of husband or wife deceased

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) May 19, 1892

8. AGE:

Years

Months

Days

If less than one day

5645

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Factory worker

11. Industry or business

MOTHER FATHER

12. Name Jacob Malczewski13. Birthplace Poland14. Maiden name Josephine Kordenski15. Birthplace Poland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9/28/48
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Ave. Balto. Md.18. Funeral director William CookAddress St. Paul and Preston Sts. Balto. M.19. Sept 27 19 48 a.m. Hidval
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 19 48 at 7:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 24 19 48 to September 24 19 48and that I last saw him alive on September 24 19 48

Immediate cause of death

Multipa Contusion
Scalp & Eye (Black Eye)
Fracture of Skull
with Extension
Subdural hemorrhage
about base of brain.

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results substantiated above Nothing definite
PHYSICIAN: Please underline the cause to which death should be attributed from

22. VIOLENCE: If death was due to external causes, fill in the following: from
Accident, probably accident, or homicide from

Where did it occur? Police Dept
(City or town) (County) (State) 9/25/48

Injured at home, farm, industry, public place (where?)

Means of injury fall

Injured at work?

23. SIGNATURE Imleamie M.D.
Deputy Medical Examiner
Address Balto. Md. Date 9/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH

County Baltimore
 City or town Beechleysville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt
 City or town Beechleysville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Maggie S. Martin

3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Charles A. Martin

7. Birth date of

deceased (mo., day, yr.)

April 9-1872

6.(c) If alive, give age

80 years

8. AGE:

Years

Months

Days

If less than one day

76510

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Ref.

11. Industry or business

MOTHER

12. Name

Ramon Cyllison

13. Birthplace

md

14. Maiden name

Angeline Kempf

15. Birthplace

md

16. Informant

Charles A. Martin

Address

24 Hampstead Rd R.O.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mr Zion

Location

Bulldco md

18. Funeral director

Eddie A. Tipton

Address

Hampstead Md

19.

(Date rec'd by registrar)

9-23-48Mary B. Elkins

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 19 1948 at 9:01 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 48 to Sept. 19 48
and that I last saw him alive on Sept. 19 48

Immediate cause of death

Carcinoma of

Due to

uterus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Porterfield
Hampstead, Md Date signed 9/20/48



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 451

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Raspeburg #6
 (b) Street address 1206 N. 62nd. Street
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore
 (c) City or town Baltimore/ Raspeburg #6
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 1206 N. 62nd. Street
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

William Pearl McCann

3 (b) If veteran, name war

Spanish

3 (c) Social Security Account

No. ---

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife. Marion V. McCann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1876

8. AGE: Years 72 Months 1 Days 20 If less than one day
 hr. min.

9. Birthplace Ohio

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Samuel McCann

13. Birthplace Ohio

MOTHER 14. Maiden Name Pearl---

15. Birthplace Unknown

16 (a) Informant Mrs. Marion V. McCann

(b) Address 1206 N. 62nd. Street

17 (a) Burial (b) Date thereof Sept. 23/48
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory U.S. National Cem

Location Balto. Md.

18 (a) Funeral director Philips Herwig Sons

(b) Address 2024 Orleans St.

19 (a) SEP 20 1948 (b) Antunich (c) Antunich
 (Date rec'd by registrar) (Signature) (Signature)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 48 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 19 48 **to** 9/20 19 48.
and that I last saw him alive on 19
Immediate cause of death Pronounced him dead

Carcinoma of Tongue

Duration

18 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....
 (b) Date of occurrence..... at..... M
 (c) Where did injury occur?.....
 (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?
 (Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny M.D.

2200 E. Madison St. Date signed 9/20/48
Hon. J. M. Aldis, M.D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

SEP 21 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09190

83a

30

Reg. Dist. No.

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred: <u>5222 Edmondson Highway</u> How long in hospital or institution?			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>5222 Edmondson Highway</u> (If rural, give LOCATION) 2.(a) If veteran, name war		
3. (a) FULL NAME <u>Rose F. McCormick</u>			3. (b) Social Security Number		
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Thomas J. McCormick</u> 6. (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) <u>Aug. 7, 1876</u>					
8. AGE: <u>72</u>	Year <u>1</u>	Months <u>17</u>	Days <u>17</u>	If less than one day hrs. min.	
9. Birthplace <u>Balto. Md.</u> (Town, county, and state)					
10. Usual occupation <u>H. W.</u>					
11. Industry or business					
FATHER	12. Name <u>John Cook</u>				
	13. Birthplace <u>Germany</u>				
MOTHER	14. Maiden name <u>Elizabeth Pfeiffer</u>				
	15. Birthplace <u>Md.</u>				
16. Informant <u>Thomas J. McCormick</u> Address <u>5222 Edmondson Highway</u>					
17. Burial (Burial, cremation, or removal. Which?) <u>Sept. 27/48.</u> (month) (day) (year) Cemetery or crematory <u>New Cathedral</u> Location <u>4300 Old Frederick Rd.</u> 18. Funeral director <u>Harry H. Witzke</u> Address <u>4101 Edmondson Ave.</u>					
19. <u>Sept 23, 48</u> (Date received by registrar)					
20. DATE OF DEATH <u>Sept. 24/48.</u> 19..... at <u>7 A</u> M					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Sept 6</u> 19 <u>48</u> to <u>Sept 24</u> 19 <u>48</u> and that I last saw <u>her</u> alive on <u>Sept 23</u> 19 <u>48</u> Immediate cause of death <u>Cerebral Hemorrhage - 3 days</u> DURATION <u>Cerebral Arterio Sclerosis</u> <u>Parkinsonian Syndrome</u> Due to Other conditions (Include pregnancy within 3 months of death) Major findings at operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?..... 23. SIGNATURE <u>Rose F. McCormick</u> M. D. or other <u>9-24</u> Address..... Date signed.....					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09188

178a

I. PLACE OF DEATH:

County Baltimore Co.City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

1410 Ridge Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1410 Ridge Road
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary Ellen McEllan (McEllan)

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth data of deceased (mo., day, year)

March 13, 1937

8. AGE: Years Months Days If less than one day

11 5 26 hrs. min.

9. Birthplace (Town, county, and state)

West Hartford Conn.

10. Usual occupation

Student

11. Industry or business

12. Name

Philip McEllan

13. Birthplace

W. Hartford, Conn.

14. Maiden name

Mildred G. Wister

15. Birthplace

Baltimore, Md.

16. Informant

Philip McEllan

Address

154 Eldbridge Rd., Hartford, Conn.17. cremation Date thereof Sept 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Md.

18. Funeral director

Edward J. McElab, Jr.

Address

Catonsville, Md.19. 9-11 1948 T.E. Harvey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 48 11/30a

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on

Immediate cause of death

asphyxiation bycarbon monoxide gas

Due to

Due to

Other conditions

gas burner turned on byMichael G McEllan (mother)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Dr. McKieffer

Address

1010 Lee Ave

Date signed

9-10-48

RECEIVED
SEP 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09187

1. PLACE OF DEATH:

County Baltimore, Co.City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

1410 Ridge Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1410 Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mildred G. McCellan (McCellan)

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 9, 1906

8. AGE:

Years

Months

Days

If less than one day

426

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

domestic

11. Industry or business

Housewife

12. Name

George Walter (WALTER)

13. Birthplace

Maryland

14. Maiden name

Hattings

15. Birthplace

Germany

16. Informant

Philip McCellan

Address

5 Weldbridge Rd, Hartford, Conn17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (Year)

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

Edward S. MacPuff Jr.

Address

Wrensville, Md.19. 9-11-48

(Date rec'd by registrar)

VE. Harry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 48 11:30 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on

19.....

Immediate cause of death

DURATION

asphyxiation by
choking on vomit

Due to

suicide

Other conditions

all burner found on
gas range in kitchen
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Sept 9 48Where did injury occur? Catonsville, Balto
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

from kitchen stove Injured at work?

23. SIGNATURE

Dr. McKieffer M. D. or other

Address

1010 Lehigh Date signed 9-10-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore Co.
City or town Catonville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
1410 Ridge Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto
City or town Catonville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1410 Ridge Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Philip Mc Lellan

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 7, 1938 8. (c) If alive, give age years

8. AGE: Years 10 Months 2 Days 2 If less than one day hrs. min.

9. Birthplace West Hartford, Conn.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name Philip Mc Lellan

13. Birthplace W. Hartford, Conn

14. Maiden name Mildred G. Waters

15. Birthplace Baltimore, Md.

16. Informant Philip Mc Lellan

Address 15 Woldbridge Rd. Hartford Conn.

17. Cremation Date thereof Sept 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium London Park

Location Baltimore Md.

18. Funeral director Edward & Mae Nabholz

Address Catonville Md.

19. 9-11-48 VE Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 48, at 11-30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death asphyxiation by
leaking gas

Due to

Due to

Other conditions in kitchen

(Include pregnancy within 8 months of death)

Major findings of operations gas burner turned on by

Mildred G. Mc Lellan Date of op. Another

Autopsy results suicide

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of Sept 9 48

Where did injury occur? Catonville Baltimore
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury gas from kitchen stove Injured at work? gas range

23. SIGNATURE Sept 11 1948 M. D. or other

Address 1010 Leeds Ave Date signed 9-11-48

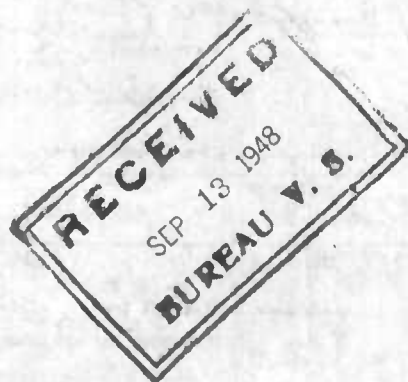
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09189

178a



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

09192

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Woodensburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Woodensburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Annie M. Meredith

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife J. Robert Meredith

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 18628. AGE: Years Months Days If less than one day
86 2 hrs. min.9. Birthplace Wilmington, Delaware
(Town, county, and state)10. Usual occupation School Teacher

11. Industry or business

12. Name John R. Padgett13. Birthplace England14. Maiden name Anna Griffith15. Birthplace England16. Informant Robert WoodenAddress Woodensburg, Md.17. Burial Date thereof Sept. 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. GileadLocation Woodensburg, Md.18. Funeral director J. F. Eline, SonsAddress Reisterstown, Md.19. 9-28 1948 Mary B. Eline.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 19 48, at 1 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-7 19 48, to 9-28 19 48.and that I last saw her alive on 9-27 19 48.Immediate cause of death Fracture of left legDue to Arteriosclerosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. D. Epler, M. D.Address Reisterstown, Md. Date signed 9-28-48

DURATION

3 da.3 yrs.

RECEIVED

OCT 1 1948

BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenn Falls Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Bennett Mimmack

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary A. Mimmack

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 18608. AGE: Years Months Days If less than one day
88 7 27 _____ hrs. _____ min.9. Birthplace Canada
(Town, county, and state)10. Usual occupation Retired secretary

11. Industry or business

12. Name Joseph Mimmack13. Birthplace England14. Maiden name Frances Bennett15. Birthplace England16. Informant Mrs. Vena WelvaretAddress Reisterstown, Md.17. Burial Date thereof Oct. 1, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverside CemeteryLocation Rochester, N.Y.18. Funeral director J. F. Eline SonsAddress Reisterstown, Md.19. 9-28 19 48 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 19 48 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 27 19 48 to Sept 27 19 48and that I last saw him alive on Sept 27 between aliveImmediate cause of death Coronary artery Disease DURATION 20 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. D. Caples, M.D. med. ExamAddress Reisterstown, Md. Date signed 9-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

09194

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 151 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or institution? 151 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1925 E. Chase Street
(If rural, give LOCATION)
2. (a) If veteran, name war WW-2

3. (a) FULL NAME

ERNEST ROBERT MOORE

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of ~~deceased~~ wife Maurice Moore

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 6-21-1907

8. AGE: Years 41 Months 3 Days 7 If less than one day hrs. min.

9. Birthplace Waynesboro, Ga.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Unknown

13. Birthplace II

14. Maiden name Frances Colman

15. Birthplace Unknown

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 10/1/48
(month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director Charles R. Law

Address 802 Madison Avenue

19. Sept 30, 48 A. W. Hedrick
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1948 at 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1948 to September 28, 1948 and that I last saw him alive on September 28, 1948

Immediate cause of death PULMONARY HEMORRHAGE

DURATION 36 hrs.

Due to Pulmonary Tuberculosis, bilateral, far advanced

7 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J. Anthony Injured at work?

23. SIGNATURE J. J. Anthony, M.D.

M. D. or other

Address VAH. Fort Howard, Md. Date signed 9-28-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. **1** Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09195

Reg. Dist. No.

30

1. PLACE OF DEATH:

County... Balto
 City or town... Catonville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since May 8, 1945
 Hospital, institution, or street address where death occurred: Spring Grove State Hosp.
 How long in hospital or institution? Since May 8, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md. County...
 City or town... Balto
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 807 N. Glen St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Anna Nuetzel

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife John Martin Nuetzel
 7. Birth date of deceased (mo., day, yr.) July 31, 1883 6. (c) If alive, give age... years
 8. AGE: Years 65 Months 1 Days 7 If less than one day
 hrs. min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Honorary
 11. Industry or business
 12. Name Kilham Bennis
 13. Birthplace Germany
 14. Maiden name Dorothy Heidt
 15. Birthplace Germany

16. Informant Spring Grove State Hosp. Records
 Address Catonville, Md.

17. Burial Date thereof Sept 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Cem.
 Location City

18. Funeral director Helbert Funeral Home
 Address 2008 Orleans St.
9-8-48

19. (Date rec'd by registrar) 19 48 Registrar D. H. Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH... 9-7-48 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19...
 and that I last saw him... alive on... 19...
 Immediate cause of death

Acute cardiac failure
 Due to...
Cardiovascular disease
 Due to...
 Other conditions...
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Dr. J. M. Smith
 M. D. or other
 Address 1010 Leeds Ave Date signed 9-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09196

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Balto.
 City or town Rockdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 years
 Hospital, institution, or street address where death occurred:
Calvert Ave.
 How long in hospital or institution? 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Rockdale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Calvert Ave.
 (If rural, give LOCATION)
 2(a) Is veteran, name war NO

3. (a) FULL NAME

ANNA W. O'CONNOR

3. (b) Social Security Number

NO

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Henry O'Connor

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1867 6. (c) Is alive, give age years

8. AGE: Years 81 Months 7 Days 17 It less than one day hrs. min.

9. Birthplace Troy, N. Y.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Richard Charlton
 13. Birthplace unknown

MOTHER 14. Maiden name Phoebe A. Jacquet
 15. Birthplace Pa.

16. Informant Mrs. Margaret J. Krug
 Address Calvert Ave., Rockdale 7, Md.

17. Burial Balto. Cem. Date thereof 9/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto., Md.

Location WM. J. TICKNER & SONS

18. Funeral director Balto., Md.

Address Balto., Md.

19. 9/25 1948 Thos E Martin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1948, at 11:55p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1948 to Sept 24 1948
 and that I last saw him alive on Sept 23 1948

Immediate cause of death Carcinomatosis

Due to Carcinoma of nose

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thos E Martin M. D. or other

Address Randallstown Date signed 9/25/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09197
38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10 Linden Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 Linden Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

JULIA THERESA O'CONOR

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Single</u>

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 20, 1869

8. AGE:	Years	Months	Days	If less than one day
<u>78</u>		<u>10</u>	<u>13</u>	hrs. min.

9. Birthplace Texas, Balto. Co., Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Hugh O'Conor13. Birthplace Maryland14. Maiden name Bridget Fahey15. Birthplace Ireland16. Informant Mrs. M.M. WatsonAddress 10 Linden Terrace, Towson, Maryland17. Burial Date thereof Sept. 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Joseph's CemeteryLocation Texas, Balto. Co., Maryland18. Funeral director John Brown's SonsAddress Towson, Maryland19. Sept 5 48 Registrar W. Carroll
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1948 at 9:35 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29, 1942 to Sept 3, 1948and that I last saw her alive on Aug. 31, 1948Immediate cause of death Heart disease, coronary with occlusion suddenDue to Heart disease chronic myocardi DURATION suddenDue to Intercranial UrbanOther conditions Intercranial

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bollin C. Hudson MD. M. D. or otherAddress Towson 4 Md Date signed 9/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09198

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: Baltimore County
 County... Agasson Pt. Md.
 City or town... (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Md. County...
 City or town... Agasson Pt. Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 720 E. St.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marion M. Offley

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1888 6. (c) If alive, give age... years

8. AGE: Years 59 Months 10 Days 25 If less than one day hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation At home

11. Industry or business

12. Name Arthur Wingard

13. Birthplace Balto. Md.

14. Maiden name Virginia Miller

15. Birthplace Virginia

16. Informant Marion M. Offley

Address 720 E. St.

17. Burial Date thereof 9-11-48 (Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland Mem. Pk.

Location Taylor Ave.

18. Funeral director John C. Miller Inc.

Address 2435 E. Olney St.

19. 9/10 48 P.W. Redrich Registrar

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-1948 at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 to Sept 8 1948 and that I last saw him alive on Sept 7 1948

Immediate cause of death Chronic lymphatic leukemia

DURATION + 5 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (when?)

Means of injury Injured at work?

23. SIGNATURE

Address 520 D St. Goldf. 9-9-48

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09199

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Wiltomdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town Wiltomdale
(If outside city or town limits, write RURAL and give nearest town)Street No. 614 Wilton Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Joyce Ann Cussler

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 14 1945

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3315

hrs. min.

9. Birthplace

Baltimore Ind

(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

FATHER

12. Name

Rodger E. Cussler

13. Birthplace

Carroll Co Ind

MOTHER

14. Maiden name

Ethel M. Cernacot

15. Birthplace

Baltimore Co Ind

16. Informant

Rodger E. Cussler

Address

614 Wilton Road

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

10-3-48
(month) (day) (year)

Cemetery or crematory

St Paul's

Location

Upperco, Balt. Co. Md

18. Funeral director

John Q. Moran

Address

3000 E. Balt. St.19. Art 1

(Date rec'd by registrar)

19 48A.W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 18 48 at 11:49 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 19 48 to Sept 29 19 48
and that I last saw h.e.r. alive on Sept 29 19 48

Immediate cause of death

Acute Leukemia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Laurence C. Loh M.D.

M. D. or other

Address 6805 York RdDate signed 9/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 93d
CERTIFICATE OF DEATH

09200

Reg. Dist. No. 30

1. PLACE OF DEATH

County Baltimore
City or town Catonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 mo
Hospital, institution, or street address where death occurred:
(Friends) Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 300 W Holly Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Florence M Mally

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Widowed

6. (b) Name of husband or wife

James W

7. Birth date of deceased (mo., day, yr.)

Sept 9 1869

8. AGE: Years Months Days If less than one day

79 9 9 hrs. min.

9. Birthplace

Kentucky

10. Usual occupation

None

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?) Date thereof

Cremation 9-18-48

Cemetery or place of interment

Location

18. Funeral director

Address

9-19-48 19-48

Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 18, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1948 to Sept 18, 1948

and that I last saw him alive on Sept 15, 1948

Immediate cause of death

DURATION

Due to

Acute cardiac failure

Due to

Cardiovascular disease

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09201

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 5 mos., 26 days
 Hospital, institution, or street address where death occurred Mt. Wilson
 Branch, Md. T.B. Sanatorium
 How long in hospital or institution? 2 yrs., 5 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1531 Lancaster Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3.(a) FULL NAME

Mrs. Mary Nueslein

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife James P. Nueslein
 7. Birth date of deceased (mo., day, yr.) August 3, 1895 6.(c) If alive, give age 53 years
 8. AGE: Years 53 Months 1 Days 19 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Joseph Kedzierski
 13. Birthplace Poland
 14. Maiden name Augusta ?
 15. Birthplace Europe

16. Informant Mrs. Mary Nueslein
 Address 1531 Lancaster St., Balto., Md.

17. Burial Date thereof Sept. 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Stanislaus Cemetery

Location Mt. Carmel Rd., Balto., Md.

19. Funeral director Fred W. Ozazewski

Address 1930 Eastern Ave., Balto., Md.

19. Sept. 22, 1948 Walter R. Hayer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1948 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946 to Sept. 22, 1948 and that I last saw her alive on September 22, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 3 yrs. 2 mos.

Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other

Address Mt. Wilson, Md. Date signed 9/22/48

RECEIVED

SEP 25 1948

BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, institution, or street address where death occurred:
Silver Lake Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Silver Lake Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

EPHRAIM EPHET PEYTON

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary F. Peyton

7. Birth date of deceased (mo., day, yr.) April 1867

8. AGE: Years 81 Months 11 Days 11 If less than one day hrs. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James Peyton

13. Birthplace Va.

14. Maiden name Mahallie Lamb

15. Birthplace Va.

16. Informant Mrs. E. E. Peyton

Address Silver Lake Drive, Fullerton, Md.

17. burial Date thereof Sept. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Poplar Cemetery

Location Balto. Co., Md.

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. Hammett Registrar
(Date rec'd by registrar) 19

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24th, 19 48, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1947 to September 24 1948, and that I last saw him alive on September 22 1948.

Immediate cause of death Chronic Cardiac decomposition DURATION years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

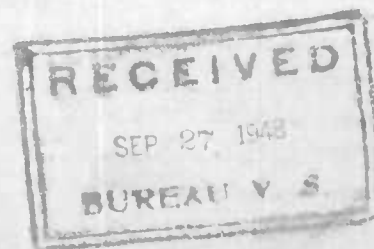
23. SIGNATURE Baldwin M. D. or other

Address Baltimore Date signed 9/24/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09203

183

44

1. PLACE OF DEATH

County Balto.
City or town Sparrow Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30y.
Hospital, institution, or street address where death occurred:
7204 River Drive Rd. Lynx Point 30y.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Berne County Berne
City or town Berne
(If outside city or town limits, write RURAL and give nearest town)
Street No. Berne
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Robert Ira Phelps

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) June 14 / 1946

8. AGE: Year 2 Months 3 Days 1 If less than one day
..... hr. min.

9. Birthplace Balto. City, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business Infant

12. Name Ira Phelps

13. Birthplace Balto. Md.

14. Maiden name Helen Ulrich

15. Birthplace Balto. Md.

16. Informant Ira Phelps

Address above

17. Burial Date thereof Sept. 18, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location 7204 Eastern Ave.

18. Funeral director Roland L. Fisher

Address 2112 Dundalk Ave.

19. Sept 17 48 Registrar A. W. Thelmer

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1948 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Drowning (accidental)

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 9/15/48

Where did injury occur? Sparrow Pt. Talbot Box Rd.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home shore

Means of injury Drowning Injured at work? Play

23. SIGNATURE Dr. Melvin M. W.

Address Balto. Dundalk Ave. Date signed 9/15/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9306 Bay Front Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catoxville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? June 3, 1948

Hospital, institution, or street address where death occurred:

Nursing home - House in the CiresHow long in hospital or institution? 1 yr. 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Catoxville
(If outside city or town limits, write RURAL and give nearest town)Street No. #16 Leeting Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Quinby

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Late Cecilia7. Birth date of deceased (mo., day, yr.) Dec 10th 1868 6. (c) If alive, give age years8. AGE: Years 79 Months 9 Days 20 If less than one day hrs. min.9. Birthplace Orange, New Jersey
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Pyron Quinby13. Birthplace Orange, N.J.14. Maiden name Mary Full15. Birthplace Orange, N.J.16. Informant Mr. Wickliffe C. QuinbyAddress 5700 Blauvargard Ave17. burial Date thereof 10/14/48
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory St. Marks Cem.Location W. Orange, New Jersey18. Funeral director John J. Cowan & SonAddress 4103 Hollins Street19. 9-30-48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30th 1948 at 2:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to September 30 1948 and that I last saw him alive on September 28 1948Immediate cause of death Myocardial Infarction DURATION 2 mo.Due to myocardial infarction 1031 (?)

Due to

Other conditions Chronic Ischemic Heart 1031 (?)

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher, M.D. M. D. or otherAddress Catoxville, Md. Date signed 9-30-48

MARGIN RESERVED FOR BINDING

VS 415 9-15-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

County Balt.City or town Eisen Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Wye 2400

How long in hospital or institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Riverdale Apt.
(If outside city or town limits, write RURAL and give nearest town)Street No. Woodvale Road
(If rural, give LOCATION)2.(a) If veteran, name war

3. (a) FULL NAME

Roberta Radebaugh

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M6.(b) Name of husband William H.7. Birth date of deceased (mo., day, yr.) July 10 - 1889 6.(c) If alive, give age years8. AGE: Years 59 Months 2 Days 14 If less than one day hrs. min.9. Birthplace Balt. Md.
(Town, county and state)10. Usual occupation at home11. Industry or business Frank Black12. Name Sophia13. Birthplace Md.14. Maiden name Md.15. Birthplace Md.16. Informant Mr. Wm. H. RadebaughAddress Riverdale Apt. Middle River17. Burial (Burial, cremation, or removal. When?) Burial Date thereof 9-27-48
(month) (day) (year)Cemetery or crematory ParkwoodLocation Baltimore18. Funeral director Longue J. LuckAddress 5305 Naylor Road19. Sept 27 19 48 A. W. Henshaw
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 19 48 at 8:00 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 19 47 to Sept 24 19 48and that I last saw him alive on Sept 24 19 48Immediate cause of death Cerebral hemorrhage DURATION 10 daysDue to Hypertensive C V disease 10 yearsDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE A. H. Kolodny M.D. M. D. or otherAddress 45-6 Edgewood Date signed Sept 24, 48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09206

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Weeks
Hospital, institution, or street address where death occurred:
Haarlem Lodge
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ma. County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2600 Lyndhurst Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

Sallie Zea Ramey

3.(b) Social Security Number
none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife xx Harry M. Ramey

7. Birth date of deceased (mo., day, yr.) November 28, 1874 8.(c) If alive, give age _____ years

8. AGE: Years 73 Months 9 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Strasburg, Va.
(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business _____

12. Name Edward Zea

13. Birthplace Strasburg, Va.

14. Maiden name Sarah William McCord

15. Birthplace Strasburg, Va.

16. Informant Edward Z. Ramey (Son)

Address 3603 Gwynns Falls Parkway

17. Burial Date thereof 9-11-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory xx Woodlawn

Location Woodlawn, Md.

19. Funeral director J. Howard Strong

Address 3207 W. North Ave.

19. 9/10 48 J.W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1948 at A. M. 1.00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/12 1948 to 9/8 1948
and that I last saw h. ER alive on 9/8 1948

Immediate cause of death CARDIAC FAILURE DURATION 12 HRS
Due to HYPERTENSION ?
Due to CANCER, UTERUS ?
Other conditions Cerebro-Vascular 3 Mos.
Accident (Stroke)
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E.P. Williamson M.D.

Address 3325 Frederick St. Date signed 9/10/48

Balto. 29 md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09207

Reg. Diat. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

29 B. Bloomsbury Ave, Catonsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt.City or town Catonville 28
(If outside city or town limits, write RURAL and give nearest town)Street No. 29 Bloomsbury Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Christopher Frederick Rappanier

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Virginia M. Rappanier

7. Birth date of

deceased (mo., day, yr.)

Sept. 2, 1855

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

93

hrs.

min.

9. Birthplace

Howard Co. Md.

(Town, county, and state)

10. Usual occupation

stone mason

11. Industry or business

self-employed

MOTHER

FATHER

12. Name

Christina E. Rappanier

13. Birthplace

Germany

14. Maiden name

Germany

15. Birthplace

Frank O. Rappanier

16. Informant

Catonville 28 Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Sept 24, 1948

(month) (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

Edinburg City, Md.

18. Funeral director

Edward St. Mary Natl

Address

Catonville, Md.19. 9-23 1948 VE Harry

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 21 1948 at 1030 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to Sept 21 1948and that I last saw him alive on Sept 21 1948

Immediate cause of death

Coronary Thromboses

DURATION

1 day

Due to

Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Stewart

M. D. or other

Address

CatonvilleDate signed 9-22

RECEIVED
SEP 24 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Jan 27, 1947
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
 How long in hospital or institution? Since Jan 27, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland Baltimore City
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2709 Gibbons Ave City 14
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

LEONARD CORBETT RIAL

3. (b) Social Security Number

4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced Separated
 6.(b) Name of husband or wife Mary Anglum
 7. Birth date of deceased (mo., day, yr.) July 18, 1898
 8. AGE: Years 50 Months 1 Days 26 If less than one day hrs. min.

9. Birthplace Baltimore City Md
 (Town, county, and state)
 10. Usual occupation Machinist

11. Industry or business

12. Name Joseph P RIAL
 13. Birthplace Baltimore Md
 14. Maiden name Mary E Kriner
 15. Birthplace Baltimore, Md.

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.
 17. Burial Date thereof 9-15-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral
 Location Baltimore

18. Funeral director

Address 5305 Harford Rd.
Sept 14 1948 A. W. Hedrick
 (Date given by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1948 at 1:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27, 1947 to Sept 13, 1948
 and that I last saw him alive on September 13, 1948

Immediate cause of death Pulmonary tuberculosis
 DURATION Since Jan 1946

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. A. Bridges M. D. or other

Address Towson 4, Md. Date signed 9-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09211

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? three months, twenty-four days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 3 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Baltimore
 City or town... Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7409 Roberts Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

CAROLYN L. ROBERTS

3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed or divorced Widowed
 6. (b) Name of husband or wife Gus Smith
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) December 28, 1877
 8. AGE: Years 70 Months 8 Days 10 If less than one day... hrs. ... min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation housework

11. Industry or business Domestic

12. Name Alexander Roberts

13. Birthplace Baltimore

14. Maiden name Mary Ellen Monroe

15. Birthplace Baltimore

16. Informant Hospital records

Address Catonsville 28, Md.

17. Burial Date thereof Sept. 10, 1948
 (Burial, cremation, or reinterment, Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Balto. Md.

18. Funeral director Philip Henwig Sons

Address 2024 Orleans St.

19. 9/7 19 48 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 14, 1948 to September 7, 1948
 and that I last saw her alive on September 7, 1948

Immediate cause of death Coronary thrombosis DURATION 6 hours

Due to Arteriosclerosis, generalized indefinite
Hypertensive cardiovascular-renal
 disease

Other conditions Hemiplegia, left 1 month

(Include pregnancy within 8 months of death)

Major findings of operations... Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville 28, Md. Date signed 9/7/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County BALTIMORE
City or town DUNDALK - GRAY MANOR
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town DUNDALK - GRAY MANOR
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3501 Mc COMAS AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GERTRUDE E. ROBERTS

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6.(b) Name of husband or wife EDWARD ROBERTS

7. Birth date of deceased (mo., day, yr.) JULY 17 1875 6.(c) If alive, give age years

8. AGE: Year 73 Month 1 Day 25 If less than one day
hrs. min.

9. Birthplace ROME, NEW YORK
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

12. Name JOHN JONES

13. Birthplace WALES

14. Maiden name ELIZABETH RICHARDS

15. Birthplace WALES

16. Informant REGINALD B. ROBERTS

Address 8215 LONG POINT RD. DUNDALK

17. REMOVAL Date thereof 9/14/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ROME

Location ROME N. Y.

18. Funeral director Wm Cork Inc

Address 1217 St Paul St

19. 9/13 x8 H W Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 12 1948 at 1200 N

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JULY 28 1948 to SEPT 12 1948
and that I last saw him alive on SEPT 12 1948

Immediate cause of death HEART FAILURE

DURATION

Due to AVICULAR FIBRILLATION 1 DAY

Due to ARTERIOSCLEROTIC C.V. DISEASE - ?

PERNICIOUS ANEMIA 2 YR.

Other conditions MULTIPLE MYELOMA 1 YR

SIMPLE FRACTURE RT. HIP 1 WEEK
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/2/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home 9/2/48 also

Means of injury auto Injured at work?

23. SIGNATURE Joseph C. Mockornick M.D.
6714 Harbord Ave M. D. or other

Date signed 9/12/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

09213
Registered No.

1. PLACE OF DEATH

(a) Baltimore City, Maryland
(b) Street address: WILKINS AVE. KENWOOD
(c) Hospital or institution: BONNIE VIEW HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Baltimore
(c) City or town 1803 WINANS AVE
(If outside city or town limits, write RURAL and give town)
(d) Street No. HALETHORPE, MD
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME

MARY N. ROBOSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F 5. Color or race W 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife NELSON O.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr) 12-10-1861

8. AGE: Years 86 Months 9 Days 12 If less than one day hr. _____ min. _____

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

FATHER 12. Name JESSIE HALL

13. Birthplace MARYLAND

MOTHER 14. Maiden Name _____

15. Birthplace MARYLAND

16 (a) Informant MRS. ALMA SOMMERVILLE

(b) Address 1803 WINANS AVE

17 (a) BURIAL (b) Date thereof 9/24/1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET
Location FREDERICK RD

18 (a) Funeral director JOHN F. DENNY, INC

(b) Address 715 LIGHT ST - 30

19 (a) 9/24/48 (b) A.W. Hedrich
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/1948, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Sept 20, 1948 and that I last saw him alive on Sept 20, 1948.

Immediate cause of death acute coronary occlusion Duration 1 day

Due to coronary artery 24/40

Due to arteriosclerosis 44/40

Other Conditions severely 54/40

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature A. B. Brumby M. D.

Address 607 Main St Date signed 9/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Armecost Nursing Home, 812 Register Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.**..... County.....
 City or town..... **Baltimore**.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **5809 Hillen Rd.**.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Suzanne H. Rose

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **W.** 6. (a) Single, married, widowed, or divorced **Widow**
 6. (b) Name of husband or wife **late Charles B. Rose**
 7. Birth date of deceased (mo., day, yr.) **March 3, 1879**
 8. AGE: Years **69** Months **6** Days **2** If less than one day
 hrs. min.

9. Birthplace **Balto. Md.**
 (Town, county, and state)
None

10. Usual occupation.....

11. Industry or business
 12. Name **Henry Heath**
 13. Birthplace **England**

14. Maiden name **Sara Ann**
 15. Birthplace **England**

16. Informant **C. Bennett Rose**
 Address **5809 Hillen Rd.**

17. **Mt. Olivet, burial** Date thereof **Sept. 7/48.**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory **Mt. Olivet**

Location **2930 Frederick Rd.**
 18. Funeral director **Harry H. Witzke**
 Address **4101 Edmondson Ave.**

19. **Sept 7 48** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept. 5/48.** 19. at **155** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March 22 1948** to **Sept 5 1948**
 and that I last saw her alive on **Sept 4 1948**

Immediate cause of death **Cerebral Arteriosclerosis**

Due to **Senility**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **J. S. Chaffard**

Address **6210 York Rd** Date signed **Sept 6, 48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09209

32

1. PLACE OF DEATH:

County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Winans Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Winans Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Wilson Ruppert

3.(b) Social Security Number

218-14-7908

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteWidowed6.(b) Name of husband or wife Hannah A. Ruppert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 18848. AGE: Years Months Days If less than one day
64 5 11 hrs. min.9. Birthplace Randallstown, Md.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name William Ruppert13. Birthplace Germany14. Maiden name Mary C. Storkee15. Birthplace Randallstown, Md.16. Informant Mr. William RuppertAddress 3612 Manchester St.17. Burial Date thereof Sept. 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive CemeteryLocation Randallstown, Md.18. Funeral director Shubert & LamoranAddress 4510 Liberty Heights Ave19. 9-24- 19 48 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 48 at 1:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9-23-1948 19 48 to 9-23-1948 19 48and that I last saw him alive on not seen alive 19 48Immediate cause of death Arteriosclerotic C.-V. Disease DURATION 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. Med. Exam.
M. D. or otherAddress Reisterstown, Md. Date signed 9-23-1948

RECEIVED

SEP 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs
 Hospital, institution, or street address where death occurred:
Apex Home, Cockeysville Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3024 Baker St
 (If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Benjamin T. Russell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Katherine Russell
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec 29 - 1854
 8. AGE: Years 88 Months 9 Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Md (Town, county, and state)10. Usual occupation Opatic packer

11. Industry or business _____

12. Name Josiah Russell13. Birthplace Virginia14. Maiden name Mary Hutchinson15. Birthplace Don't know16. Informant L. M. SchroederAddress Masonic Home Cockeysville17. Burial Date thereof Sept 28 - 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid CemeteryLocation Baltimore Md18. Funeral director Wm. CookAddress St. Paul & Preston St19. 9/20 19 48 L. M. Schroeder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 19 48 at 8:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1 19 47 to Sept 20 19 48and that I last saw him alive on Sept 20 19 48Immediate cause of death Heart Failure DURATION 2 weeksDue to Arterio sclerosis 13 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter J. Kees M. D. or otherAddress Cockeysville Md Date signed 9/22/48

RECEIVED
SEP 21 1948
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: *Baltimore*
 County *Baltimore*
 City or town *Turner Station - 22*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *13 yrs*
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *MD* County *Baltimore*
 City or town *Turner Station - 22*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *677 So. Arundale Rd.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Will Ryno (Round) (Rynes)* 3. (b) Social Security Number

4. Sex *M* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *Elizabeth Round*
 7. Birth date of deceased (mo., day, yr.) *June 20, 1901* 6. (c) If alive, give age years
 8. AGE: Years *47* Months *2* Days *13* If less than one day *14 hrs. 10 min.*

9. Birthplace *Chester, S. C.*
 (Town, county, and state)

10. Usual occupation *Laborer*

11. Industry or business *Bethlehem Steel Corp.*

12. Name *Will Round*

13. Birthplace *S. C.*

14. Maiden name *Mary Reed*

15. Birthplace *S. C.*

16. Informant *Elizabeth Round*

Address *677 So. Arundale Rd*

17. (Burial, cremation, or removal) *Burial* Date thereof *Sept - 8, 1948*
 (month) (day) (year)

Cemetery or crematory *Mt Auburn*

Location *Baltimore, Md.*

18. Funeral director *Charles R. Law*

Address *802 Madison Ave.*

19. *9/7 x R Dr. Medical* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *September 4, 1948* at *5:30 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *September 3, 1948* to *September 4, 1948* and that I last saw him alive on *September 4, 1948*

Immediate cause of death *Broncho - Pneumonia*

DURATION *1 Day*

Due to

Due to

Other conditions *Rheumatic Fever*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *William C. Hade, M.D.* M. D. or other

Address *140 Oak Ave* Date signed *9-4-48*

MAINTAINED FOR BINDING

I

VS A15-41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 yrs
 Hospital, institution, or street address where death occurred:
129 Bloomsbury Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 Bloomsbury Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Gideon N. Sauter

3. (b) Social Security Number

216-28-6901

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Widower
 6. (b) Name of husband or wife Laura Edna Sauter
 7. Birth date of deceased (mo., day, yr.) Feb. 13, 1888
 8. AGE: Years 60 Months 5 Days 25 It less than one day hrs. min.

9. Birthplace Woodlawn, Md
(Town, county, and state)10. Usual occupation Plastering11. Industry or business Contractor12. Name Charles C. Sauter13. Birthplace Maryland14. Maiden name E. Edna Sauter15. Birthplace Maryland16. Informant F. Key SauterAddress 129 Bloomsbury Ave17. Burial Date thereof Sept 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine Park Cem.Location Woodlawn, Md18. Funeral director Easton SonsAddress 608 Frederick Ave. Catonsville19. 9-9 19 48 VE. Horrey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7, 1948 at 6³⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 19 48 to Sept 7 19 48
 and that I last saw him alive on Sept. 8 19 48

Immediate cause of death Coronary thrombosis
 DURATION 20 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. V. Williamson MD M. D. or otherAddress 4508 Edmondson Village Date signed Sept 7, 1948
Pauls. 29

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

09217

1. PLACE OF DEATH:

County Baltimore
 City or town Rossville, Rural- Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Rossville, Rural- Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box. 284 Ridge Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

KATHERINE DOROTHY SCHEPF

3. (b) Social Security Number

None

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Wm. Henry Schepf6. (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) April 7, 1882

8. AGE: Year 63 Months 5 Days 18 If less than one day
 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Daniel Malkus
 13. Birthplace Maryland

MOTHER 14. Maiden name Margaret ?
 15. Birthplace Maryland

18. Informant Mr. Wm. H. Schepf
 Address Bx. 284 Ridge Rd. Baltimore -6

17. burial Date thereof 9/29/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore cemetery

Location Baltimore, Maryland
HENRY SANDER & SONS, INC.

18. Funeral director NORTH AVE. & BROADWAY
 Address

19. Sept 28 48 A. W. H. H. H. H.
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 48 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1944 to Aug 20, 1944
 and that I last saw her alive on Aug 20, 1944

Immediate cause of death

Cerebral Haemorrhage DURATION 1 hour

Due to Hypertensive Cardio Vasc Disease 10 yrs?

Due to General Arteriosclerosis 15 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations . Date of op. .

Autopsy results .
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide . Date of .

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .Means of injury . Injured at work? .

23. SIGNATURE W. H. H. H. H. M. D. or other
 Address Ridge Rd. Dist. 6 Md. Date signed Sept 27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09218

41

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto
 City or town Dundalk
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: 6800 Martin Ave.
 Stay in hospital or inst. (yrs., or mos., or days) 12 yrs.
 Stay in this community (yrs., or mos., or days) 12 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Balto
 City or town Dundalk Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. 6800 Martin Ave
 (If rural give LOCATION)
 2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME

George Schlaffer

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Minna Homberg

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7/18/65

8. AGE: Years 83 Months 2 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Balto
(Town, county, and state)10. Usual occupation Retired Brewer

11. Industry or business

12. Name Frank Schlaffer13. Birthplace Germany14. Maiden name Anna C. Stiel15. Birthplace Germany16. Informant Bertha A. SchlafferAddress 6800 Martin Ave17. Burial Date thereof 9/25/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Easton Ave Exd.18. Funeral director Tilly & Zuck JrAddress 403 S. Wolfe St19. Sept. 23 19 48 Shelton M. Kelly Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/1948 at 3:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 43 to Sept 22 19 48and that I last saw him alive on Sept 21 19 48Immediate cause of death Heart Disease DURATION 10 yrsSecondaryCoronary Artery Disease 15 yrs

Due to _____

Other conditions _____

Major findings: (Include pregnancy within 8 months of death)

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

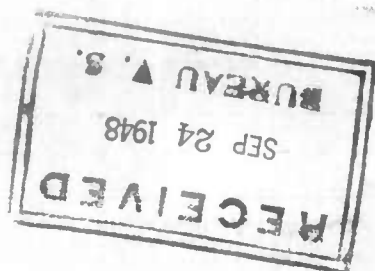
23. SIGNATURE M. C. Davis M. D. or other _____Address Dundalk - Md Date signed 9/23/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Davis



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09219

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armocost Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County 2City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1711 E. 31st. Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

CECELIA ELIZABETH SCHLINGMAN

3. (b) Social Security Number

NONE

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Widow</u>
--------------------	------------------------------	---

6.(b) Name of husband or wife Frederick Schlingman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1878

8. AGE:	Years	Months	Days	If less than one day
<u>70</u>	<u>2</u>	<u>17</u>hrs.min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Charles Ritz13. Birthplace Berlin, Germany14. Maiden name ? Funk15. Birthplace Switzerland16. Informant Mrs. Marie GaertnerAddress 1711 E. 31st. Street - 1817. Burial Date thereof 9/18/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Md.18. Funeral director HENRY SANDER & SONS, INC.Address NORTH AVE. & BROADWAY19. 9-18-48 A.W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948 at 11.25 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1948 to Sept 15 1948 and that I last saw him alive on Sept. 15 1948Immediate cause of death Cerebral Hemorrhage DURATION 3 daysDue to hypertensive thrombosis 3 yrs.Due to arteriosclerosis 3 yrs.Other conditions Chronic Bronchitis
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. N. Heger M. D. or otherAddress 1521 E. 33rd Date signed 9/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH County..... <u>Baltimore</u> City or town..... <u>Anneslie, Baltimore 12</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>9 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Anneslie, Baltimore 12</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>501 Overbrook Rd.</u> (If rural, give LOCATION) 2. (a) If veteran, name war..... <u>No</u>			
3. (a) FULL NAME <u>Marie Elizabeth Schroeder</u>				3. (b) Social Security Number <u>-</u>			
4. Sex <u>Female</u>				5. Color or race <u>White</u>			
6. (a) Single, married, widowed, or divorced <u>Married</u>				6. (b) Name of husband or wife <u>David Marshall Schroeder</u>			
7. Birth date of deceased (mo., day, yr.) <u>Aug 1, 1899</u>				6. (c) If alive, give age <u>55</u> years			
8. AGE: <u>49</u> Years <u>1</u> Months <u>6</u> Days <u>hrs.</u> min.				9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>				11. Industry or business <u>Own home</u>			
12. Name <u>William Henry Rigley</u>				13. Birthplace <u>Baltimore, Md.</u>			
14. Maiden name <u>Claire Miller</u>				15. Birthplace <u>Baltimore, Md.</u>			
16. Informant <u>David Marshall Schroeder</u> Address <u>501 Overbrook Rd. Balt 12</u>				17. Burial <u>Yes</u> Date thereof..... <u>9/9/48</u> (Burial, cremation, or removal. Which?) (month) (day) (year)			
Cemetery or crematorium <u>St. Olivet</u>				Location <u>Guthrie, Md.</u>			
18. Funeral director <u>E. J. Lanning & Son</u> Address <u>1938 E. Lafayette Ave.</u>				19. 9/5 <u>AS Hedrick</u> (Discovered by registrar) <u>DR</u> Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>Sept 6 1948</u> <u>APPROX. 3 A.M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>19</u> <u>10</u> <u>19</u>							
and that I last saw <u>None</u> <u>19</u>							
Immediate cause of death <u>Acute congestive cardiac failure due to acute alcoholism</u>							
Due to							
Due to							
Other conditions <u>Arthritis, chronic, multiple</u> <u>2 yrs.</u>							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.....							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: <u>None</u>							
Accident, suicide, or homicide Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>Rollin B. Hudson MD D.M.E.</u> M. D. or other							
Address <u>Towson Md.</u> Date signed <u>9/6/48</u>							

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 108

09221

XX

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
VAH FT. Howard, Md.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.Co.
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ✓ (If rural, give LOCATION)
 2.(a) If veteran, name war WW-1

3. (a) FULL NAME

HORACE SEDGWICK

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ida Sedgwick
 7. Birth date of deceased (mo., day, yr.) December 18, 1893 6.(c) If alive, give age 44 years
 8. AGE: Years 54 Months 8 Days 16 If less than one day
 hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation farming
 11. Industry or business
 12. Name Horace Sedgwick
 13. Birthplace Maryland
 14. Maiden name Lizzie Arthur
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland
 17. Burial September 9, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Townesneck,
Arundel Co., Md.
 Location

18. Funeral director Joseph A. Lively
 Address 661 W. Barre St., Baltimore, Md.

19. 9/7 19 48
 (Date rec'd by registrar) Registrar R. W. Sedgwick

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 19 48 at 2:25 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 19 48, to Sept. 4 19 48
 and that I last saw him alive on Sept. 4 19 48

Immediate cause of death LOBAR PNEUMONIA DURATION Unknown

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings at operations
 Date of op.
 Autopsy results Substantiated Above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. L. Rithmeyer, M.D. M. D. or other
 Address VAH Fort Howard, Md. Date signed 9-4-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09222
38

1. PLACE OF DEATH: THE SHEPPARD AND ENOCH PRATT
County BALTIMORE (HOSPITAL)
City or town TOWSON
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years, 3 mos., 15 days
Hospital, institution, or street address where death occurred:
The SHEPPARD AND ENOCH PRATT HOSPITAL
How long in hospital or institution? 23 years, 3 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Illinois County Cook
City or town Chicago
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 West Monroe Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SEGER, ALLISON

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife H. G. Seger, deceased

7. Birth date of March 4, 1859 6. (c) If alive, give age _____ years
deceased (mo., day, yr.) unknown-said to be Mar. 4, 1860
or 1864

8. AGE: Years Months Days If less than one day
89 8 6 6 _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Stewart
13. Birthplace Scotland
(first name not known)
14. Maiden name Allison Rae (ALLISON RAE)
15. Birthplace Scotland

16. Informant HOSPITAL RECORDS alsoAddress Miss Mary Bell-Tudor Arms Ball

17. Burial Date thereof 9-11-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Louisa ParkLocation Baltimore18. Funeral director Stewart-Morgan Co.Address 108 W. 4th Ave.

Sept 11 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10th 19 48 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 25th 19 25 to Sept. 10th 19 48
and that I last saw her alive on September 10th 19 48

Immediate cause of death Broncho pneumonia DURATION 2 da

Due to

Due to

Other conditions Senile Psychosis 25 yr

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did it occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

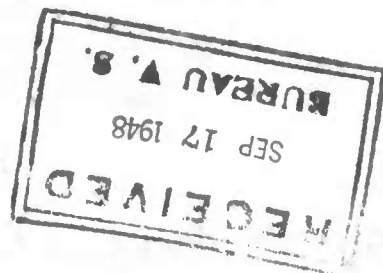
23. SIGNATURE M. Elgin M. D. or otherAddress Sheppard-Pratt Hospital Date signed Sept 10, 1948Address Towson 4, Md. Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



09223

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, MarylandHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1929 Wilkins Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war WWI

3. (a) FULL NAME

CHARLES E. SEWELL

3. (b) Social Security Number

Unknown

4. Sex

MALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Eunice Sewell6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

11-25-85

8. AGE:

Years

Months

Days

If less than one day

62924

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Sexton

11. Industry or business

FATHER

12. Name Joseph Sewell13. Birthplace Unknown

MOTHER

14. Maiden name Mary ???15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9-11-48

(month) (day) (year)

Cemetery or crematory London Ph-Location Baltimore - Md18. Funeral director William Cook, Inc.Address 1717 St. Paul St.19. Sept 20

19

48A. W. H.H.H.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 18, 1948, to September 19, 1948and that I last saw him alive on Sept. 19, 1948Immediate cause of death CEREBRAL VASCULARHEMORRHAGE, WITH RIGHTHEMIPLEGIA.

DURATION

24 hrs.

Due to

Due to Generalized arteriosclerosisunknownOther conditions None

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Charles S. Hester, M.D.

M. D. or other

Address Ft. Howard, Md.Date signed 9-19-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS ATB

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

09224

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH: Baltimore
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Sudden - Fair Grounds
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Phoenix
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Joseph Howard Sheeler

3. (b) Social Security Number
212-07-6108

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Agnes Sheeler
 7. Birth date of deceased (mo., day, yr.) July 22, 1895
 6. (c) If alive, give age 51 years
 8. AGE: Years 53 Months 1 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Ashland, Balt Co. Md.
 (Town, county, and state)

10. Usual occupation Electrician
 11. Industry or business Gas & Electric Co.

12. Name Howard Sheeler
 13. Birthplace Cockeysville, Balt Co. Md.

14. Maiden name Josephine Sheeler
 15. Birthplace Phoenix, Balt Co. Md.

16. Informant Mrs. Joseph A. Sheeler
 Address Phoenix, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof 9-7-48
 (Month) (day) (year)

Cemetery or crematory St. Joseph's Methodist
 Location Sparks, Md.

18. Funeral director Scott Brooks
 Address Sparks, Md.

19. 9-7- 19 48 Wilmer C. Ensor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 19 48 at 1:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 _____ to _____ 19 _____
 and that I last saw him/her alive on _____ 19 _____

Immediate cause of death Heart disease, coronary occlusion Sudden

Due to Chronic heart disease, type not determined 5 yrs +

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Bollin G. Hudson M.D. D.M.E.
 Address Towson Md Date signed 7/4/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age in especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH 512

Registered No. 58555

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 4 Riverside Rd.
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Ind. (b) County
- (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 4 Riverside Rd.
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

Phillips Eric Sides

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. 5. Color or race W 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-47

8. AGE: Years 1 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Daniel P. Sides13. Birthplace S.C.14. Maiden Name Ethel Ethel15. Birthplace S.C.16 (a) Informant Same(b) Address Same17 (a) B. (b) Date thereof 10-2-48
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory C. Hill
Location Back for18 (a) Funeral director James H. Brown(b) Address 30 S. State19 OCT 1 1948 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1948, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1948 to 9/30 1948, and that I last saw him alive on Sept 27 1948.

Immediate cause of death BRONCHIAL PNEUMONIA Duration Sept-48

Due to METASTATIC CARCINOMA April-1948Due to MALIGNANCY OF RT-TESTICLE JAN-1948

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6 months agoMajor findings of operation: Malignant RT-Testicle

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Shot23. Signature Eric Sides M. D.Address 320 Cadapace Ave Date signed 10/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

OCT 4 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09226

Reg. Dist. No. 44

1. PLACE OF DEATH
 County Balto.
 City or town Middle River P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs.
 Hospital, institution, or street address where death occurred:
Eastern ave.
 How long in hospital or institution? 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Balto. County Balto.
 City or town Balto.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Balto.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Silvers.

3. (b) Social Security Number

4. Sex Male 5. Color or race Cal. 6. (a) Single, married, widowed, or divorced Widowed.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) about 1871

8. AGE: 7 Years Months Days It less than one day

9. Birthplace Martinsburg W. Va.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Unknown13. Birthplace W. Va.14. Maiden name Unknown15. Birthplace W. Va.16. Informant Joseph CarringtonAddress Burgies Md17. Burial Date thereof Sept. 17 1948

(Burial, cremation, or removal Which?)

Cemetery or crematory Sharp St. CemeteryLocation Burgies Md18. Funeral director Robert E. WilliamsAddress 1515 Mc Elroy St19. Sept 16 48 (Date rec'd by registrar)20. John J. Connolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1948 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death Coronary Arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE McKearns M.D.Address Balto. Md Date signed 9/14/48

RECEIVED
NOV 5 1948
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09227

1. PLACE OF DEATH:

County Baltimore - 22City or town Bundack
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

8207 N. Boundary Rd.How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town RD in # 1 Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2215 Fleet Street

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME

Katherine Slipper

3. (b) Social Security Number

X

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Charles Slipper

7. Birth date of

deceased (mo., day, yr.) April 16, 18656. (c) If alive, give age 80 years

8. AGE:

Years 80 Months 5 Days 5 If less than one day — hrs. — min. —

9. Birthplace

Charleston, S. C.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

own home

FATHER

12. Name John Feldt house in13. Birthplace Germany

MOTHER

14. Maiden name Anna Feltenberger15. Birthplace Germany

16. Informant

Carrie RileyAddress RD in # 1

17.

Burial Date thereof 9/24/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Stewart's

Location

6th & D Street

18. Funeral director

Lilly & Zeiler Inc.Address 4031 S. W. 1st St.19. 9/22 19 48 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 20, 1948 at 11 P. M. 45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 10, 1948 to Sept. 20, 1948and that I last saw him alive on Sept. 20, 1948

Immediate cause of death

Myocardial failureand pulmonaryedema } 2 daysDue to Arteriosclerosis } 10 yrsOther conditions Senility } 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Louis M. Tolliv. M.D.6908 North St. Rd Balto 19 M.D. or other Sept 24/48

Evidence for change of

age shown on:

RUM No. G 117 SEP 21 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Therese Czeck (Stachow)

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jacob Czeck6. (c) If alive, give age 1 years

7. Birth date of

deceased (mo., day, yr.)

10/15/82

8. AGE:

Years

Months

Days

If less than one day

167 65 11

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Calwoman

11. Industry or business

Daniel Huczko

MOTHER FATHER

12. Name

Daniel Huczko

13. Birthplace

Poland

14. Maiden name

Catherine (?)

15. Birthplace

Poland

16. Informant

Mr. Catherine Paskiewicz

Address

222 N. Chester St.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sep 14 1948
(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Baltimore City

18. Funeral director

John M. Weber

Address

401 S. Chester St.

19.

(Date rec'd by registrar)

19.

9/13 88 Dr. W. H. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 19 48 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/1719 47to 9/1019 48and that I last saw her alive on 9/10 19 48

Immediate cause of death

Cardiac Failure

DURATION

Due to

Cachexia
bronchogenic carcinoma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

David J. Phillips, M.D.

M.D. or other

Address Spring Grove State Hosp Date signed 9/10/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09229

Reg. Dist. No. 30

1. PLACE OF DEATH:

County **Baltimore**
 City or town **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 yr., 9 mos., 18 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **1 yr., 9 mos., 18 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County
 City or town **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **2029 E. 31st Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

M.

Elizabeth Starkey

3. (b) Social Security Number

4 Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced **Divorced**
 6.(b) Name of husband or wife **Vernon J. Starkey**
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) **July 10, 1894**
 8. AGE: Years **54** Months **1** Days **29** If less than one day hrs. min.

9. Birthplace **Maryland (Baltimore)**
 (Town, county, and state)
 10. Usual occupation **Housewife**
 11. Industry or business **Domestic**
 12. Name **Edward Heinze**
 13. Birthplace **Maryland (Baltimore)**
 14. Maiden name **Mary Schwimm**
 15. Birthplace **Maryland (Baltimore)**

16. Informant **Hospital Records**
 Address **Catonsville-28, Maryland**
 17. Burial **Baltimore** Date thereof **9/11/48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Balto., Md.**
 Location
 18. Funeral director **WM. J. TICKNER & SONS**
 Address **Balto., Md.**

19. **9-10-48** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **September 9** 19**48** at **8:45 a.m.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 22** 19**46** to **Sept. 9** 19**48**
 and that I last saw her alive on **September 9** 19**48**

Immediate cause of death **Coronary thrombosis** DURATION **1 hr.**

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations **Prefrontal lobotomy** Date of op. **8-17-48**
 Autopsy results **None**
 PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?)
 Means of injury **Isadore Tuerk, M.D.**
 Injured at work?
 23. SIGNATURE **Isadore Tuerk, M.D.** M. D. or other
 Address **Catonsville-28, Maryland** Date signed **Sept. 9, 1948**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09230

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Balto.
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Balto
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 604 Upland Rd. Sudbrook
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Janie Patterson Stitt

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 18 1913

8. AGE:

34

Years

9

Months

25

Days

If less than one day

hrs.

min.

9. Birthplace

Pikesville Md

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Herbert D. Stitt

13. Birthplace

Arkansas

MOTHER

14. Maiden name

Mary Penhelt

15. Birthplace

Balto. Md

16. Informant

Mrs. Herbert D. Stitt

Address

Pikesville. Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sept 10 1948

Cemetery or crematory

Dried Ridge

Location

Pikesville Md

18. Funeral director

Henry W. Jenkins & Sons Co

Address

4905 York Rd. Balto 12

19.

(Date rec'd by registrar)

9-13-

1948

Dr. E. E. Nichols

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12 1948 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 34 to Sept 12 1948
and that I last saw him alive on Sept 11 1948

Immediate cause of death

DURATION

Retroperitoneal tumor

Feb 1948

Due to

not diag. med.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Retroperitoneal tumor

Date of op. Feb. 48.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Palmer H. Williams MD.

M. D. or other

Address: Pikesville Md Date signed Sept 12



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years or more
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Melvin Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grace L. Sullivan

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William S. Sullivan

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) February 5-1889

8. AGE:

69725

It less than one day

hrs. min.

9. Birthplace Towson, Balt. Co. Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Edward Burns

13. Birthplace

Maryland

MOTHER

14. Maiden name

Margaret Stone

15. Birthplace

Maryland

16. Informant

Mr. William S. Sullivan

Address

Melvin Ave

17. Burial

(Burial, cremation, or removal)

Date thereof

Oct. 2-1948
(month) (day) (year)

Cemetery or crematory

St. Johns Cemetery

Location

Ellicott City, Howard Co. Md

18. Funeral director

Geo. F. Beyer Jr

Address

1512 Hillcrest Baltimore, Md

19. (Date filed by registrar)

10/1/48

19

A. W. Housh

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 30 1948 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1946 to Sept 30 1948

and that I last saw him

Sept 29 1948

Immediate cause of death

Coronary Thrombosis

DURATION

1 day

Due to

Hypertensive Cardiovascular Disease

Due to

Other conditions

Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Grace L. Sullivan

M. D. or other

Address

Catonsville Date signed 10/1

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. James S. Howell
715 Indiana Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09232

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Days
 Hospital, institution, or street address where death occurred:
Veterans Adm. Hospital, Ft. Howard, Md.
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1823 Eagle Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

CLARENCE W. THOMAS

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of deceased's wife Carrie Thomas
 6. (c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) 3-30-92
 8. AGE: Year 56 Month 5 Days 27 It less than one day _____ hr. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name John W. Thomas
 13. Birthplace Maryland

MOTHER 14. Maiden name Margeline Fields
 15. Birthplace Eastern Shore, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Oct. 2, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
 Location Charles R. Law

18. Funeral director 802 Madison Ave., Balto., Md.
 Address

19. Sept 30, 1948 R. W. Hedrick
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1948 at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23, 1948 to September 27, 1948
 and that I last saw him live on September 27, 1948

Immediate cause of death

CARDIAC DILATATION AND HYPERTROPHY
WITH PULMONARY EDEMA

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE H.C. MANAUGH

H.C. MANAUGH, M.D. Chief Pro. Ser.

Address VAH, Ft. Howard, Md. Date signed 9-28-48

729 Canton
Canton Hills
H

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Balto.

City or town Ruxton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

City or town Ruxton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

OTTO R. THOMAS

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Iva Jenkins Thomas

7. Birth date of deceased (mo., day, yr.)

April 19, 1891

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

57

4

27

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Co. Tax Office

Balto. Co.

11. Industry or business

FATHER

12. Name

Henry G. P. Thomas

13. Birthplace

Germany

MOTHER

14. Maiden name

Mary Parke

15. Birthplace

Balto.

16. Informant

Mrs. Iva J. Thomas

Address

Ruxton, Md.

17.

Burial

Date thereof

9/20/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Druid Ridge Cem.

Pikesville, Md.

Location

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

19

48

A. D. Hedrich

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 16

1948

at 9-A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19..... to 19.....

and that I last saw h.....

Immediate cause of death

Heart disease, coronary with occlusion - sudden

DURATION

Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin L. Hudson M.D. D.M.F.

M. D. or other

Address

Towson Md.

Date signed

9/16/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

09234

37

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Timonium
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Lifetime
Hospital, institution, or street address where death occurred:.....
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Baltimore
City or town..... Timonium
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Northwood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war..... no

3. (a) FULL NAME

Emma Caroline Lumbaug

3. (b) Social Security Number

none

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Albert Lumbaug

7. Birth date of deceased (mo., day, yr.)

Oct. 23, 1882

8. (c) If alive, give age..... years

58

8. AGE:

Years

Months

Days

If less than one day

65

10

27

..... hrs. min.

9. Birthplace

Balto. Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

John W. Wolfe

13. Birthplace

Balto. Co., Md.

14. Maiden name

Elizabeth Burke

15. Birthplace

Balto. Co., Md.

16. Informant

Albert Lumbaug

Address

Timonium

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Sept. 20, 1948
(month) (day) (year)

Cemetery or crematory

St. Johns

Location

Sweet Air, Balto. Co., Md.

18. Funeral director

Samuel M. Brooks

Address

Sparks, Md.

Sept. 20, 48

Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 17, 1948, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept. 1946 to Sept. 17, 1948

and that I last saw him/her alive on

Sept. 16, 1948

Immediate cause of death

Heart Failure

DURATION

10 days

Due to

Rheumatic Heart

Due to

Myocardial Infarction

6 months

Due to

Cancer of Pancreas

3 yrs +

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles F. Donald MD
M. D. or other

Address

7301 York Rd

Date signed

9/18/48

RECEIVED

RECEIVED

RECEIVED

RECEIVED
SEP 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09235

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Twin River Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Twin River Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ernest Vesely

3. (b) Social Security Number

218-03-4710

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1903

8. AGE: Years 45 Months 3 Days 16 If less than one day hrs. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual occupation Czechoslovakian's helper

11. Industry or business

12. Name John

13. Birthplace Czechoslovakia

14. Maiden name Katherine Ludwig

15. Birthplace Czechoslovakia

16. Informant Mrs. Marie Langkam

Address 2601 Mura St.

17. Burial Date thereof 9/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill

Location Horner's Lane

18. Funeral director Clarence F. Hoffmann

Address 1639 N. Broadway

19. 9-3 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th 1948 at 8:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Drowning

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sys.

Where did injury occur? Twin River Beach, Balt. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Gun Powder River, Gun Powder River.

Means of injury Went swimming alone, when

dark & failed to come up Injured at work? No.

SIGNATURE M. B. Davis M.D.

Address Medical Examiner, Baltimore

Date signed 9/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date & age, shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09236

FILM No. G 117 OCT 7 1948 CERTIFICATE OF DEATH 932

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville Farms

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Viau

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

B. (b) Name of husband or wife Thomas Viau

7. Birth date of

deceased (mo., day, yr.)

May 3, 1880

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

686954267

hrs.

min.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Joseph J. Cairns, Sr.

13. Birthplace

Ireland

MOTHER

14. Maiden name

Mary McGarran

15. Birthplace

Ireland

16. Informant

Louise Viau

Address

Orchard Rd., Pikesville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 2, 1948

(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Pikesville, Maryland

18. Funeral director

Frank H. Newell

Address

Pikesville-8, Md.

19.

10/148

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Pikesville Farms

(If outside city or town limits, write RURAL and give nearest town)

Street No. Orchard Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1948, at 11-PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17, 1948, to Sept. 28, 1948and that I last saw her alive on Sept. 28, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

2 yrs.

Due to

Arterio Sclerosis

Due to

Other conditions Gall bladder disease(probably gallstones)

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. E. Richards

M. D. or other

Address

Pikesville-8, Md.

Date signed

10/1/48

RECEIVED

OCT 4 1948

BUREAU V. S.

Ex-100-33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction
of age shown on:

FILM No. G 117 OCT 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09237

Reg. Dist. No. 41

1. PLACE OF DEATH:

County... Baltimore

City or town... Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15m

Hospital, institution, or street address where death occurred:

210 Arundel Rd

How long in hospital or institution?

3. (a) FULL NAME

Mollie Halker

4. Sex

F

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

5/2/1906

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

42

1

18

1 hrs.

min.

9. Birthplace

Brunswick, Va.

(Town, county, and state)

10. Usual occupation

Refrigerator Operator

11. Industry or business

Ice Room

MOTHER FATHER

12. Name

Alphonse Halker

13. Birthplace

Brunswick, Va.

14. Maiden name

Hennrichs Brasley

15. Birthplace

Brunswick, Va.

16. Informant

Mrs. Kenneth B. Jones

Address

210 Arundel Rd

17.

(Burial, cremation, or removal. Which?)

Sept 23 1948

Cemetery or crematory

Lacrosse Rd

Location

18. Funeral director

Isaiah L Brown & Son

Address

108 W. Montgomery St

19.

(Date rec'd by registrar)

19

1948

ASD Helmer

Don

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

Street No.

210 Arundel Rd

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 20, 1948, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

June 15, 1948, to September 20, 1948

and that I last saw her alive on September 20, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 min

Due to

Hypertension (Essential)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William J. Smith M.D.

M. D. or other

Address

100 Oct Ave

Date signed 9-22-48

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09239

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 11 mos., 21 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium
How long in hospital or institution? 1 yr., 11 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Charles Co.
City or town Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war. _____

3. (a) FULL NAME

John Nicholas Wathen

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) September 16, 1916 6. (c) If alive, give age _____ years

8. AGE: Years 32 Months 0 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Wathen

13. Birthplace Newport, Maryland

14. Maiden name Frances Stonestreet

15. Birthplace Gallent Green, Maryland

16. Informant John Nicholas Wathen

Address Newport, Chas. Co., Md.

17. Burial Date thereof Sept. 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Newport, Chas. Co., Maryland

18. Funeral director Huntt & Ryan

Address Waldorf, Maryland

19. Sept. 20, 1948 Helen R. Mayer
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1948 at 4:00 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30, 1946 to Sept. 20, 1948 and that I last saw him alive on Sept. 20, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 6 yrs.

Due to Tubercle Bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mens of injury _____ Injured at work? _____

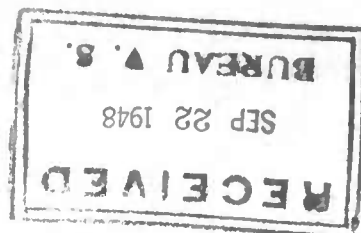
23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other _____

Address Mt. Wilson, Md. Date signed 9/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

09240

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 1 mo., 14 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T.B. Sanatorium
 How long in hospital or institution? 0 yrs., 1 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 218 S. Payson Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War II

3. (a) FULL NAME

Joseph R. Weaver

3. (b) Social Security Number

212-12-5748

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>Doris Weaver</u>			
7. Birth date of deceased (mo., day, yr.) <u>March 21, 1920</u>			
8. AGE: Years <u>28</u>	Months <u>6</u>	Days <u>5</u>	If less than one dayhrs.min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER
 12. Name Francis Weaver
 13. Birthplace Seattle, Washington

MOTHER
 14. Maiden name Josephine Weaver
 15. Birthplace Baltimore, Maryland

16. Informant Joseph R. Weaver

Address 218 S. Payson St., Balto., Md.

17. Burial Date thereof Sept. 29, 1948
 (Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location 5501 Fred. Ave., Balto., Md.

18. Funeral director John J. Cowan & Sons

Address 901 Hollins St., Balto., Md.

19. Sept. 26, 1948 Nolan R. Meyer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1948 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1948 to Sept. 26, 1948 and that I last saw him alive on Sept. 26, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 6 mos.

Due to Tubercle bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other

Address Mt. Wilson, Md. Date signed 9/26/48

RECEIVED
OCT 1 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09241

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Glenn Falls Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Julien Joseph Welvaert

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Celine Reiss Welvaert
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 3, 1871
 8. AGE: Years 77 Months 2 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Belgium
 (Town, county, and state)
 10. Usual occupation Architect
 11. Industry or business
 12. Name Joseph Welvaert
 13. Birthplace Belgium
 14. Maiden name Justine Mattele
 15. Birthplace France

16. Informant Albert T. Welvaert
 Address Reisterstown, Md.
 17. Burial Date thereof Sept. 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory All Saints
 Location Balto. Co.
 18. Funeral director J. F. Elmer, Sons
 Address Reisterstown, Md.
 19. 9-24 1948 Mary B. Elmer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 19 48 at 1:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-17 19 47 to 9-22 19 48
 and that I last saw him alive on 9-21 19 48

Immediate cause of death
arteriosclerotic changes 10 da.
of Rt. Foot.
 Due to arteriosclerosis 2 yrs.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. D. Caples, M.D. M. D. or other
 Address Reisterstown, Md. Date signed 9-24-48

RECEIVED

SEP 25 1948

W. B. REARD

RECEIVED

SEP 25 1948

W. B. REARD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09242

Reg. Dist. No.

1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...City or town... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 4614 Falls Road
(If rural, give LOCATION)2.(a) If veteran, name war... P. I.

3. (a) FULL NAME

EDWARD WEST

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Mary West

7. Birth date of

deceased (mo., day, yr.) March 9, 18656. (c) If alive, give age 49 years

8. AGE:

Years

Months

Days

If less than one day

8365

hrs.

min.

9. Birthplace... Norfolk, Virginia

(Town, county, and state)

10. Usual occupation... Unemployed

11. Industry or business

MOTHER FATHER

12. Name

William

13. Birthplace

Virginia14. Maiden name... Unknown

15. Birthplace

Virginia16. Informant... Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

9-20-48
(month) (day) (year)

Cemetery or crematory

Baltimore National Cemetery

Location

Baltimore, Maryland

18. Funeral director

Charles R. Law

Address

802 Madison Ave., Balto., Md.19. Sept 17 19 48 A. W. Helms
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 14 19 48 at 9:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 6 19 48 to September 14 19 48and that I last saw him alive on September 14 19 48Immediate cause of death Carcinoma of lungs
with metastasis

DURATION

3 mos +

Due to

Due to

Other conditions Hydrothorax and Heart
Failure2 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton Ginsberg M.D.Address VAH. Fort Howard, Md Date signed 9/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore (Dundalk)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 330 Flicker Court
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-II

3. (a) FULL NAME

LAWRENCE A. WEST

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 10-28-11 8. (c) If alive, give age years

8. AGE: Years 36 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Manager Store

11. Industry or business

12. Name George West
 13. Birthplace Maryland

14. Maiden name Unknown
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Baltimore National
 (Burial, cremation, or removal. Which) Date thereof Sept 22, 1948
 (Month) (day) (year)
 Cemetery or crematory Baltimore, Md.
 Location Charles F. Law

18. Funeral director Charles F. Law
 Address 802 Madison Avenue

19. 9/20 48 G W Friedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1948 at 4:35 A.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 27, 1948 to September 18, 1948
 and that I last saw him alive on September 18, 1948

Immediate cause of death RUPTURE OF LEFT KIDNEY, SPONTANEOUS; HUGE RETROPERITONEAL HEMATOMA

DURATION

12 hrs.

Due to

Due to Thrombosed Vein 12 hrs.

Other conditions Acute Pyelonephritis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE HB Chapin M.D.
 M. D. or other

Address Ft. Howard, Md. Date signed 9-18-48

09243

19521

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Balto.
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Percy Williams

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Mar 27 - 1868 6. (c) If alive, give age..... years

8. AGE: Years 80 Months 5 Days..... It less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cremation Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Sept 18 19 48 C. E. Arthur

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 19 48 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 2 19 47 to Sept 17 19 48, and that I last saw him..... alive on Sept 16 19 48

Immediate cause of death.....

Cerebral Thrombosis DURATION 7 da.

General Arteriosclerosis 5 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D. M. D. or other

Address..... Folk, Md. Date signed 9/18/48

MARGIN RESERVED FOR BINDING

VS A13 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09245

Reg. Dist. No. 97

1. PLACE OF DEATH:

County Baltimore
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred:
Masonic Home, Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2206 Roslyn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary L. S. Wooten

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Charles Edward Wooten

7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1868 6. (c) If alive, give age 79 years

8. AGE: Years 80 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Hebron Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Judge Wm. H. Seth

13. Birthplace Hebron Md.

14. Maiden name Sarah Eleanor Hopkins

15. Birthplace Trappe, Md.

16. Informant Laura M. Schroeder

Address Masonic Hospital, Cockeysville

17. Burial, cremation, or removal, Which? Burial Date thereof Sept. 25, 48
(month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore

18. Funeral director Wm. Cole

Address St. Paul & Preston St

19. Sept. 23, 1948 Registrar L. M. Schroeder

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 19 48 at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Sept. 22 19 48

and that I last saw her alive on Sept 22 19 48

Immediate cause of death Coronary Thrombosis DURATION 4 days

Due to Hypertension 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M. D.

Address Cockeysville Md Date signed 9/22/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09246

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7022 Dunbar Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 7022 Dunbar Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ruth V. Yeager

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

M.

6.(b) Name of husband or wife

Harry J. Yeager

7. Birth date of

deceased (mo., day, yr.)

September 21, 1904

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

431125hrs.min.

9. Birthplace

Carroll Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Wm. A. Le Brun

13. Birthplace

Baltimore, Md.

14. Maiden name

Mellie Smith

15. Birthplace

Carroll Co., Md.

16. Informant

Harry J. Yeager

Address

7022 Dunbar Road, Dundalk

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 19, 1948
(month) (day) (year)

Cemetery or crematory

Shiloh

Location

Hampstead, Carroll Co., Md.

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave., Dundalk, Md.

19.

(Date rec'd by registrar)

Sept 18 1948 William M. Kelly Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16th 1948 at 10⁴⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1938 to Sept. 1948
and that I last saw him alive on Sept. 15 1948

Immediate cause of death

Br - Latent Pulmonary Tuberculosis

DURATION

12 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

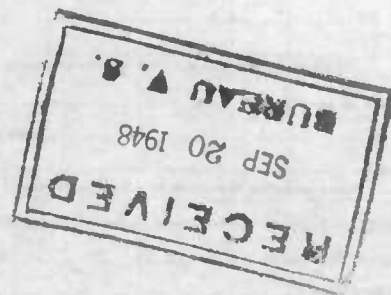
Injured at work?

23. SIGNATURE

W B Davis MD
Dundalk - Md

M. D. or other

Date signed 9/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 6 mos., 3 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 0 yrs., 6 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2016 Penrose Avenue
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Harry E. Young

3. (b) Social Security Number

216-05-0652

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Claudia C. Young
 6. (c) If alive, give age 36 years
 7. Birth date of deceased (mo., day, yr.) March 23, 1911
 8. AGE: Years 37 Months 5 Days 19 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Truck Driver
 11. Industry or business

12. Name Harry Pohlmann Young
 13. Birthplace Baltimore, Md.
 14. Maiden name Carrie Fultz
 15. Birthplace Elkton, Virginia

16. Informant Harry E. Young
 Address 2016 Penrose Ave., Balto., Md.
 17. Burial Date thereof Sept. 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Louden Park Cemetery
 Location Baltimore, Maryland
 18. Funeral director Geo. L. Beyer, Jr.
 Address 1512 Hollins St., Balto., Md.

19. 9/11/48 19
 (Date rec'd by registrar) Registrar John R. Mayer

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1948 at 9:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1948 to Sept. 11, 1948
 and that I last saw him alive on Sept. 11, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Larynx 3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other
 Address Mt. Wilson, Md. Date signed 9/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09248

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore
City or town _____
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
1226 Ten Oaks Rd - B27
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Baltimore
City or town _____ Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1226 Ten Oaks Rd 27
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Mrs Robt. R. Younghus Jones (-GEATRUPE)

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Robt R.
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) May 15 - 1902
8. AGE: Years 46 Months 4 Days 16 If less than one day ✓ hrs. ✓ min.

9. Birthplace Wexley, England
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business _____
12. Name Arthur H. Dunn
13. Birthplace England
14. Maiden name Sarah N. GREEN
15. Birthplace England

16. Informant John Bond
Address 1226 Ten Oaks Rd.

17. BURIAL Date thereof SEPT. 20 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT OLIVET
Location INDIANA AVE

18. Funeral director Harry A. Witzke
Address 4101 Edmonson Ave

19. Sept 18 19 48 Dr. Kieffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1948, at 4A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Sept 18 1948, and that I last saw her alive on Sept 16 1948

Immediate cause of death Carcinoma of breast DURATION 5+ yrs

Due to with generalized metastases

Due to Cachexia 3+ yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma PHYSICIAN _____

Of autopsy ✓ Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?


23. SIGNATURE Frederic V. Bester M. D. or other

Address 723 Medical Arts Bldg Date signed 9-18-48
Baltimore - md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr.
Balderson 
and later

Arb 214 - Proffers

